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THE TREATMENT OF STRANGULATED HERNIA.

(*Continued from page* 133.)

My readers will have assumed from what I wrote in my last number that I am an apologist for the Taxis. A careful examination of the recorded results of the treatment forty years ago and that of the present time has impressed me strongly with the belief that a patient in whom a hernia had become strangulated, had formerly a far better chance of survival than he has now. This is a serious and somewhat humiliating admission. The chief change which has taken place has been consequent on disparagement of the taxis, and a refusal to believe that the operation has in itself any dangers. As the subject is one full of difficulty, and as great care is needed in order to avoid error in marshalling the facts, I shall perhaps consult the convenience of all if I attempt to find answers to a few explicit questions.

1. What was the ratio of fatality of strangulated hernia in former times?

2. What is it now?

3. Does the taxis increase the dangers of the case? and if so, how?

4. Does an operation in itself involve any increase of risk?

5. In what proportion of cases ought we to expect to succeed by taxis?

In seeking answers to the first two of these questions, it

is necessary to assert that we must ascertain the fatality of strangulated hernia and not of herniotomy. It is most unfair to compare the results of different surgeons, or of different periods, by formulating the statistics of operations only. We must take for our calculations all cases in which strangulation existed. In hospital practice it is not very difficult to define "strangulation," and probably the cases admitted with that diagnosis into the wards of our hospitals are fairly comparable. If a hernia-case is brought to a hospital, the house-surgeon, supposing it to be not a severe one, makes an examination and a brief attempt at taxis. If he succeeds, the patient probably returns home, and if otherwise, is sent into the ward. Some difference may obtain at different institutions in the degree of zeal, as to taxis, shown by the house-surgeon. If almost all cases are admitted, the surgeon will have a certain number of milder, and more easily recoverable, cases to treat than he would otherwise obtain. We will assume, however, that in the admission books and statistical reports of our various hospitals, the term "strangulated hernia" means pretty much the same thing—that it designates a case of hernia in which a first attempt at taxis, by some one, has failed, and in which there is more or less tendency to sickness.

Now it is, as just stated, quite obvious that we must take the total of all these cases into consideration in our attempts to estimate the success of different methods of treatment. Supposing two surgeons, the one a taxist and the other not, to have each under his care twenty patients with strangulated hernia, the one might reduce fifteen and operate on five, while the other might reduce five and operate on fifteen. The taxist might afford to lose every one of his operations and yet have on the whole better statistics than his colleague who had lost only half. Thus we see that it is most unfair to speak of a surgeon's herniotomy success as if it represented his success in the treatment of strangulated hernia. An excellent illustration of this is afforded by the records recently published by a veteran surgeon in a provincial city.

During the five years 1867 to 1871, Mr. L—— had at the Infirmary to which he is surgeon 8 operations for strangulated

hernia. Four were for inguinal hernia and 4 for femoral. There were 6 fatal cases, 2 inguinal and 4 femoral. Thus it appears that all the femoral cases operated on ended fatally (and in one, it may be remarked, the duration of strangulation had been only sixteen hours). There is no statement that in any of the cases in which an operation was done, the sac was not opened. Against what may appear to have been somewhat untoward results, we have to set the fact that during the period of hospital experience to which these statements refer, Mr. L—— succeeded by the taxis in 16 cases, and presumably all these cases recovered. Of these, 15 were cases of inguinal hernia. Thus it is probable that during this period Mr. L—— took much pains with the taxis. His results as regards inguinal hernia would appear to have been as follows. Nineteen patients came under his care with strangulated inguinal hernia, 4 being women and 15 men. Out of this number only two died, one man and one woman. The success was in the main due to the taxis, for 15 of the number were not operated on, and they all recovered.

It was needful to attempt a definition of the term "strangulation" before we could discuss the statistics of treatment of strangulated hernia. There is, however, no need to define *Herniotomy*, and it might at first sight seem to be an easy thing to construct statistics as regards operations for hernia, such as should admit of an easy comparison between different institutions and different modes of practice. As a matter of fact, however, it is exceedingly difficult to do so; and, as might easily be shown by citations of the statements of authors, such statistics might prove very misleading. Thus we have it on Mr. Fergusson's authority, that Mr. Luke, during the period that he was accustomed to open the sac, lost about one patient in every three on whom he operated, but that, after he changed his practice in this respect, out of nearly forty operations he lost only two. The difference between 1 in 3 and 1 in 20, and that on the authority of a man so trustworthy as the late Mr. Luke, might seem to be conclusive in favour of the new method; yet the operation without opening the sac can scarcely be said to have held its ground, and when the results

of practice at St. George's Hospital, where the sac was almost always opened, and at the London, where the endeavour was constantly made to avoid doing so, were compared, it was found that the balance was slightly in favour of the old method. No one can doubt that some error had crept in, in reference to Mr. Luke's statistics. No one familiar with the general conditions of hernia operations, however skilfully done, and by whatever method, can believe that it is possible that nineteen out of twenty of such patients can be saved. A much larger proportion than that are, from the very nature of the case, doomed to death before the operating surgeon is called in. I receive with like incredulity some statements as to successes, which have recently been reported in the English press from a Swedish source.

In the statistical fragments which I am about to quote, much will be left to the reader's own judgment. He must estimate the facts for himself, and make all due allowances for error. Only those well informed in details can use statistics to advantage.

In an able letter from the pen of Mr. Bowlby, which appeared in the *Lancet* a few months ago, and in which statistics collected by Mr. Berry were quoted, it was admitted that the present mortality of hernia operations, taking them all together, is not less than 43 per cent. These statistics are published by Mr. James Berry, in the St. Bartholomew's Hospital Reports for 1884, and are based on 940 cases, treated consecutively in St. Thomas's, Guy's, and St. Bartholomew's. In the same letter it is stated that Mr. Treves had admitted, respecting the London Hospital, that the recent average of mortality had been nearly 50 per cent. Mr. Bowlby succeeds in showing that at St. Bartholomew's during the last ten years the mortality did not quite reach 38 per cent., and I believe that Mr. Treves' statement was liable to a considerable reduction. Probably, however, we shall not be very far from the truth if we believe that at present in the London hospitals, the deaths after hernia operations amount to 40 per cent. At the present time, as I have said, early operations are the rule. No delay whatever is permitted after the patient comes under hospital care. In the

great majority of cases the sac is opened, under the now prevalent opinion that incision of the peritoneum does not increase the risk. Some form of antiseptic is probably used, either during the operation or afterwards, in most cases, and lastly, as an important addition to what was formerly done, we must note that, in a very considerable proportion of cases, the operator adopts measures for the radical cure by obliteration of the sac.

Mr. Southam has recorded for us the recent statistics at the Manchester Royal Infirmary. Taking the twelve years' period from 1881 to 1893, they are as follows. Total number, 85 cases, with a fatality of 44·7 per cent. The fatality in inguinal was nearly 39 per cent.; in femoral, 40·5; and in umbilical, 75.

A statistical table of operations at the London Hospital for sixteen months, October, 1860 to January, 1862, compiled by Dr. Woodman, shows that nearly one operation a week had occurred. The inguinal cases were nearly as frequent as the femoral. The gross mortality was 40 per cent.

In 1864, at the London Hospital, there were 27 operations for strangulated hernia, 13 for femoral, 10 for inguinal, 4 for umbilical. Twelve out of the 27 patients died. Seven of the cases were my own, and 3 of these were inguinal. The sac was not opened in 13 of the cases, and of these 5 died. In one case of inguinal hernia, which had been strangulated only five hours, and in which the taxis had scarcely been used, the patient died of peritonitis. He was a healthy young man of 28. In another case the strangulation had existed only two hours, and in a third only three hours. In neither of the two latter was the sac opened, and in both the patients recovered.

In 1865, at the London Hospital, there were 24 hernia operations, and the mortality was more than 40 per cent. Six of the cases were mine, 5 femoral and 1 inguinal. In 1866 there were 29 cases of strangulated hernia which required operation. Of these, no fewer than 18 were inguinal, and only 11 femoral. Eight of the operations were my own. I am glad to say that only one of these eight

was an inguinal hernia. These two years taken together give me 14 operations, and only 2 for the inguinal form. The year 1867 was a favourable year, for out of 20 operations only 5 patients died. There is no obvious explanation of this good result. Most of the cases had been strangulated several days, and in two only was the period less than twenty-four hours. There were 7 inguinal and 12 femoral, and 1 was a *reductio en masse*. The sac was not opened in ten of the cases, and the whole of these ten recovered.

In the year 1875, during which I did not operate at the London Hospital on one single case of strangulated hernia, 24 operations were done by my colleagues. Of these 14 died. Nine of the cases were inguinal, 14 femoral, and 1 umbilical. Of the femoral 11 died, and of the inguinal only 3.

The statistics compiled by my son for the London Hospital, during the years 1885 to 1889 inclusive (during which time he was Registrar), show a total of 100 operations. The fatality was 50 per cent.

In a paper published by Mr. Hancock in the *Lancet* for 1849, we have a large collection of cases from various authors with a view to determine average fatality. Most of the facts had been previously tabulated by Mr. Gay. The total shows a fatality of 32·5 per cent., the whole number of cases being 872.

During the present year Mr. Rushton Parker has recorded his personal experience of 49 cases, which gave precisely this same fatality, 32·5 per cent.

Mr. John Birkett, in a paper read before the Medical Society of London, recorded the results of 26 cases of femoral hernia under his own care. One half had terminated fatally. In 14 cases the sac was not opened, and Mr. Birkett expresses an unhesitating opinion in favour of what he calls the minimum operation, *i.e.*, not opening even the fascia propria. Of the fatal cases, in one strangulation had existed only eleven hours. Some of these cases were in private practice.

In a discussion on Mr. Birkett's paper, Mr. Hunt stated, in reference to the taxis, that he had never failed to succeed, and that on one occasion he had employed it continuously for

two hours and twenty minutes without intermission, and with success at last.

The following facts may help us to some estimation of the results at St. Thomas's Hospital twenty years ago.

In 1866 there were 16 herniotomies, with 7 deaths. The sac was opened in all excepting two; 7 were for inguinal and 9 for femoral hernia.

The statistics for 1871 are so stated that it is extremely difficult to abstract them without risk of error.

The same remark applies to those of 1872; but it would appear that in this year, of 6 operations for inguinal hernia, 5 of the patients died, whilst of 7 for femoral only 1 died; and that of 3 for umbilical 2 died.

In 1873 the total of operations was 14; 9 males and 5 females. Of these 8 recovered, and 6 died. No details are given.

In 1874 there were 16 operations, 10 males and 6 females; 8 deaths and 8 recoveries.

In 1875 there were 21 operations, with 7 recoveries and 14 deaths. All the five patients operated on for inguinal hernia and the single one for umbilical died.

In speaking of the effects of delay and the effect of prolonged strangulation, Mr. Luke (the London Hospital) records the following facts. Of sixty-nine patients operated on within forty-eight hours, only twelve died; of thirty-eight after the expiration of forty-eight hours fifteen died; and of thirteen others, in whom the length of time was doubtful, six died. These cases comprise different methods of operating as regards opening the sac; but were all in the hands of the same surgeon. They give a gross mortality of 27½ per cent.; that is, not much more than one in four.

Still more extraordinary successes are recorded by Mr. Luke at p. 107, where he states that only two out of twenty operations for inguinal hernia died; and only two out of thirty-one for femoral hernia. At the time that Mr. Luke was obtaining these extraordinary results it was, I believe, his invariable practice to give purgatives after the operation. Mr. Luke was a sober-minded man, not given to boasting; but it is impossible not to suspect that some fallacy underlies

his statistics. At the present day (as I have already remarked) a larger percentage of cases come under the operator's care in a stage which is absolutely hopeless than Mr. Luke's whole mortality would cover. Part of his most unusual success must be attributed to the dexterity and care with which he performed his favourite operation. This explanation of his results cannot, however, be allowed to go very far.

In St. George's Hospital during the year 1865 there were 16 operations for strangulated hernia, the sac being opened in all but one. Eleven of the cases were for femoral hernia, 4 for inguinal, and one for umbilical. Eleven of the patients recovered. All the deaths were in cases of femoral hernia. In one of them, strangulated only for eighteen hours, it was expressly stated that the intestine was healthy. One patient had sharp secondary hemorrhage, and in another suppuration in the cellular tissue of the scrotum retarded the recovery. In a third, recovery was retarded by suppuration in the sac, and another is recorded to have died of exhaustion from profuse suppuration in the sac. I mention these facts in order to show that accidents attend herniotomy operations, which must not be forgotten by those who speak as if it had no dangers.

Before attempting to suggest any comparison of the results with those of former years, I must again ask attention to a fallacy to which I have already referred. It is this—that in proportion to the smallness of the number of cases of strangulated hernia reduced by the taxis ought to be the improvement in the ratio of recoveries after the operation. The success of an individual surgeon, or of a hospital, should always be calculated in reference to the total number of strangulated hernias coming under care. It is obvious that, if out of a hundred such cases one surgeon reduces fifty by the taxis, whilst another on principle almost wholly declines that method of treatment, and does not reduce more than five, that the success of the operations performed by the latter ought to be far better than that of the former.

The surgeon who thinks it his duty to succeed by taxis if he can, and uses it perseveringly and successfully, leaves only a residuum of the least hopeful cases for his operation-

statistics. This I must confess appears to me to be much the position in which the surgery of the present, as regards this operation, stands to that of the past. I am quite willing to believe that those surgeons who speak in disparagement of the taxis, and make it almost a boast that they never use it, are guilty of exaggeration, and do not do themselves justice. After making much allowance on this score, it is still probably true that a far smaller proportion of cases of strangulated hernia are reduced by the taxis now than was the case fifty years ago. It is not very easy to collect statistics to prove this, for but few surgeons have thought it worth while to record the number of their taxis successes. I have, however, been able to get a few items of evidence, which may help us to realise the truth.

The facts which I will next quote bear upon the questions as to—

The danger which attaches to the Taxis, and the proportion of cases which may be so reduced.

A statistical paper by Mr. W. Money records the experience of the Northampton General Infirmary from August, 1813 to August, 1814. A total of 157 patients applied on account of hernia. Of these, seven were strangulated—one femoral, and six inguinal. In not a single one was an operation required, and inferentially all reduced by taxis recovered.

During the year 1864, 67 patients applied at the London Hospital for hernias which could not be reduced at home. In 5 of these the house surgeons succeeded in reduction in the receiving-room, and the patient went home forthwith. Sixty-two were admitted to the wards. Of these, 35 were men, and 28 women. Only twenty-four out of the 62 were operated on; and of these, 11 died. There is no reason to believe that any of those in whom the hernia was reduced by taxis died, and the real fatality of strangulated hernia in this year is therefore not quite 1 in 6.

From Mr. Luke's paper in the thirty-first volume of the Medico-Chirurgical Transactions, I learn that, between the years 1842–47, 293 patients were admitted into the London Hospital with strangulated hernia. In 206 of these taxis

was successful, and, so far as was known, not a single one of these died. This would give an average of about fifty hernia cases a year, and nearly fifteen operations. Mr. Luke does not appear to have been himself acquainted with any deaths after taxis; but he states that Mr. King had recorded no fewer than four cases of death out of forty, and Textor nine out of 114. Mr. James, of Exeter, in his monograph on hernia, writes in a similar strain. He knew that cases of death after taxis had been recorded, but he had not himself met with any.

As illustrating the proportion of successes by taxis in modern practice, we find reported from the Sahlgrennan Hospital, in Gothenburg, a total of admissions for "Incarceration of Hernia" during the nine years, 1883 to 1892, 155 cases, out of which only 22 were reduced without operation. Notwithstanding this proof of promptness, the fatality of the herniotomies was 24 per cent.*

Mr. Luke's experience at the London Hospital, at a time when more than two-thirds of the cases of strangulated hernia were reduced by taxis, and when it was customary to make, as he says, very protracted efforts, was that of those submitted to operation and in which the sac was opened the mortality only reached one-third. That in the cases in which the sac was not opened was far less; only seven out of fifty-nine having died. Facts such as these do not lend any support to the opinion, now so freely expressed, that attempts at forcible taxis prejudice the chances of the patient if an operation be necessary.

* It is only right that I should add that the reporter of these facts believes that the mortality occurred chiefly in the earlier periods, and that it had been reduced during the last two years to less than 10 per cent. By the side of this statement we may suitably place Mr. Luke's statistics. They differ so much from general experience that we can but suspect some fallacy.

(To be concluded.)

ON CATARRHAL ERUPTIONS.

I HAVE to propose the recognition of a group of diseases of the skin which is, I think, a perfectly natural one, but which has hitherto for the most part escaped attention. Having first given a definite signification to the term "catarrhal," I shall suggest that there are certain definite affections of the cutaneous surface which bear a very similar relation to catarrhal causes which the well recognised affections of the mucous membranes of the nose, throat, &c. do. By "catarrhal causes" are meant such influences as cold and damp, the exposure to which produces through the nervous system congestions and inflammatory action in a more or less distant part. They are to be carefully distinguished from such local results of local applications of cold as frost-bite, chilblains, and the like. A reflex disturbance of nerve balance, a certain degree of general fever, limited duration, tendency to spontaneous recovery, and liability to recurrences, are essentials in our conception of a truly catarrhal malady. During the more or less prolonged intervals the patient is usually quite well. All catarrhal maladies show a definite tendency to symmetry, and in this feature are to be separated from the herpetic group, which in many respects are nearly related.

If there are any affections of the skin which may be properly called catarrhal, they ought to show definite tendency to apparently spontaneous recurrence, and should be capable of spontaneous decline. They ought further to have symmetrical manifestations, and to be attended by a certain slight amount of disturbance of general health.

We might further expect that the subjects of them should in some instances recognise an association with catarrhal

causes, and have noticed that the skin affection occurred as a substitute for some of the other more common catarrhal manifestations. We must not, however, expect much very definite evidence on this latter point from the patients themselves, since the dissimilarity of an affection of the skin from a cold in the head or an attack of sore throat will generally be sufficient to have prevented any suspicion of identity of cause. If there be affections of the skin which are catarrhal, we have for the most part overlooked their real nature ourselves, and we can scarcely expect that our patients should have observed it.

It will be observed that in the definition of catarrh which I have suggested, no importance is attached to the nature or quantity of the secretion attending a catarrhal inflammation. The definition depends upon the speciality of cause and course, and not peculiarity of result. It can lead, I think, only to confusion if we allow ourselves to apply the term catarrhal to all inflammations of mucous membranes attended by excess of secretion, since many of these have, as regards their cause, no relation whatever to the typical forms of catarrh. Nor must it be supposed that all catarrhal inflammations are affections of mucous membrane or are attended by secretion. The type of inflammatory action will vary according to the tissue which is affected, and may be plastic as in croup and pleurisy, mucous and watery as in a common cold in the head, or synovial in the case of rheumatic fever. In the instance of the skin we may expect it to take somewhat various forms, either merely congestive, attended with interstitial effusion, or with the formation of bullæ.

The diseases of the skin which I have to mention as constituting a catarrhal class, have, of course, not been overlooked by dermatologists. They have been well described, but have not been assigned to any special cause. Foremost amongst them is the malady vaguely known as erythema multiforme. The bullous eruption on the hands and feet for which many years ago I suggested the name of Cheiropompholyx, and which, as being liable to definite recurrence, I claimed as a neurosis, is probably another.

Some of the cases which have been called erythema iris, and some which have been named hydroa should also be thus grouped. Thrombotic Purpura, when it is recurrent after irregular intervals, may not improbably be catarrhal. Should it be objected that some of the maladies named are rheumatic, I must reply that in many instances the terms rheumatic and catarrhal are almost synonymous. Of the truly rheumatic affections, as distinct from gout and rheumatic gout, the same statements may be made as regards nature of cause, mode of manifestation, limited duration, and spontaneous recovery which I have suggested as the characteristics of catarrh. For me rheumatic fever is acute catarrhal arthritis. Bearing these facts in mind, I will now submit to the consideration of my readers the details of some cases of considerable interest in which I think that the diagnosis of catarrhal dermatitis may fairly be made.

CASE I.—*A recurring Catarrhal eruption on hands, feet, and ears, with Herpes of lips and symmetrical Herpes on the cheeks—Erythema Iris type of eruption.*

The case which follows seemed in a remarkable manner to mix the phenomena of the summer eruptions with those of cheiro-pompholyx and Raynaud's disease. The patient, Charles Drummond, was, when I first saw him, a lad of fourteen. The circulation in his extremities was very peculiar. His hands were dusky red and cold, and easily became stiff and blue when exposed. Bullæ had occurred on his hands and ears as in the "summer eruptions," but their occurrence did not appear to have been at all under the influence of weather. That the disease was constitutional and probably a neurosis of a somewhat different character to Raynaud's malady was shown by the occurrence of vesicles inside his cheeks, parts not much under the influence of external disturbances of the circulation. Further, it must be added that the disease followed the type of a recurring herpes or catarrhal malady, in always showing definite tendency to spontaneous cure. The longest attack he had ever had was not more than three weeks, and some had been over in a week or ten days. In

this tendency to spontaneous recovery and in its independence of weather the disease differed altogether from the "summer eruptions." The eruption when occurring on his feet had never affected his toes, but had occurred with symmetry on his heels. It is further to be noted, as possibly pointing to another alliance, that he had had threatenings of a patch on the fronts of both knees. The character of the eruption was very definite. It began as a little vesicle, which would burn and tingle, and at first contained fluid. The fluid was rapidly absorbed, and the epidermis again adhered, but the vesication would spread at its edge until a circle the size of a split pea, a sixpence, or a shilling, was produced. The amount of fluid under the slightly elevated edge was very little, and the epidermis everywhere adhered for a time. Thus no real bullæ were produced, nor any abraded surfaces. At the time that he came to me the palms of his hands were covered with little circles, which were quite flat except for a little elevation at their edges. The eruption was not attended by much swelling of the parts. When I saw him it affected the palms of the hands chiefly. There were, however, some abortive bullæ on the backs of the hands, and I was told that on former occasions it had often been abundant there. He was a lad of remarkably fair complexion and thin skin. His mother stated that in early life his hands used to get very hot, that he used often to mention that they were very hot, and she asserts that they used almost to burn her when he touched her. Suddenly, about three years ago, this ceased, and they became very cold. The liability to the eruption began three years ago.

The lad's mother had noticed that he looked bloated and puffy in the face before the eruption appeared, and was languid. He used also to frequently get a "hot lip." His mother had been accustomed to attribute the attacks to catching cold. The hot lip would always come first, and next a spot on his ear, and then some on the hands. He often at the onset complained of feeling cold and shivery. Thus it seemed clear that the attacks were of a catarrhal nature.

The following were the facts which were given me in regard to the history of his illness. He lived at Charlton, in Kent, on the chalk hills.

His first attack was in November, 1887. It began like "nettle-rash," and itched very much; the mouth also inflamed. He became ill, and was in bed for ten days. The doctor stated that his temperature was very high. The patient got very thin while in bed. For some time after he got up his appetite was bad, and he ate very little, but he gradually got well again. The skin eruption disappeared, and it was not till the following Easter that he had another attack.

This was the only time (in November) that he was ever confined to bed by an attack. The Easter attack began in the same way as the first, with itching spots on the hands and a few in the mouth. A small blister formed in both attacks on the rim of each ear. He was not on the second occasion seriously ill in himself.

The third attack was in August, and for this he went to the Stamford Street Hospital. It lasted about ten days, the eruption occurring chiefly in the hands. He had no further attacks during the winter, and it was not till the following spring that the eruption appeared again. This attack was about the same in severity as the present one. This was the only attack that year. The attacks this year have been in April, June, and August, and now for a fourth time in November. In the August attack the spots occurred only on the backs of the hands. He was then staying at the seaside. He found that as soon as he put his hands into sea-water they became stiff and cold. The lad states that his lip has always been the first part sore.

The above notes were taken in November, 1890. On November 14, 1890, I demonstrated the case before my post-graduate class. The lad was then in the stage of decline of an attack. Three days previously I had seen him with numerous vesicles with spreading edges on his fingers and palms. When brought before my class all the vesicles had dried up.

The patches in palms were of a dull brown tint, and peeling was about to commence in their centres. Some of them showed in the middle a little dull red point which marked the spot where the patch began.

He was a tall, well-grown lad, but pale and puffy. The sores inside the cheeks were healing just as herpes would. He could eat well.

I determined to try the effect of a long course of arsenic as a preventive remedy.

The date of my next seeing this lad was May 6, 1891, when he had taken with tolerable regularity for nearly six months three minims of Pearson's solution of arsenic, in bark, three times a day. The remedy had agreed well, and much im-

proved his appetite. He had been much more free from the eruption, and was in better health. He was still liable to rapid changes in congestion of face. His mother said that all round his mouth he would often become pale, whilst his cheeks were red. He was still very liable to a form of herpes on his lips. He never suffered from chilblains.

On May 20th Drummond came to show me a fresh outbreak. There were only a very few spots, but they were quite characteristic. They had appeared almost simultaneously on the backs of the hands, on the palms, and on the fronts of the knees. They consisted of rings of erythema with raised edges, which looked exactly as if they were going to vesicate. No vesications were, however, really formed. The patches spread at their edges and became again flat in their centre. The process ended by desquamation, but without any effusion of fluid or formation of crust. His spots were arranged with very exact symmetry; there were only two or three on the back of each hand, and two or three in each palm; all being in exactly corresponding places. His hands and cheeks were as they had always been, very florid, with a slight tendency to become dusky. He could not assign any special cause for the attack, excepting, perhaps, that he had had a cold. His mother said that the attacks occurred independently of weather. In this instance they began on a Saturday, which was a very cold day immediately following three very hot days, and he had been a good deal chilled at school. He had some sores inside the cheeks on both sides on the day that the eruption began. These had quite healed when he came to me four days later.

It is to be understood that the present attack is a very slight one compared to what he formerly had. His mother states that he is very liable to what she calls hot lip (herpes), when he catches cold. She states that vesicles also form on the inner side of the lobes of his ears.

At this date (May, 1891) I wrote the following comments on the case:—

Comments.—It appears very probable that this eruption is of a catarrhal-herpetic character. It differs, of course, from herpes in its most definite symmetry. His mother states

that on the day he came home from school ill he was very cold. The change of temperature that week had been one of the most extraordinary ever known, the difference by thermometer being between Wednesday and Saturday nearly 50°. The case, which was the subject of the New Sydenham Society's portrait, and which was definitely cured by arsenic, was probably of a somewhat similar nature. In the present instance the arsenical treatment which the boy has had for rather more than four months, though it has not absolutely prevented the attacks, has very much diminished their severity.

I did not see Drummond again until the spring of 1892. He had continued the arsenic in doses of five minims, and had had but one attack since his last visit to me, and it a very slight one, involving only the palms of the hands. He was no longer liable to any vesicles on his lips or ears, but these parts would sometimes smart if he came out of the cold into a warm room. He looked well.

A few weeks ago (Nov. 7, 1893), at my request, Drummond attended at one of my lectures at the Clinical Museum. I then read over the notes of his case, and showed three portraits illustrating conditions somewhat similar to those which he had formerly displayed. In himself there was nothing to be seen. He was now a tall, well-formed young man of seventeen. He stated that he had been quite free from attacks since I had last seen him, and that he had left off his arsenic. He considered that he was sometimes threatened when he took cold, but the eruption never developed. We may therefore consider him as now cured. Whether the arsenic is to be credited with his present immunity, or whether he has simply grown out of his liability, must be left an open question. I am inclined to believe that the drug has taken a definite share.

CASE II.—*Catarrhal attacks of Erythema, followed by peeling of the skin of the neck and hands—Patient a delicate man of middle age, liable to very profuse perspiration.*

The following case appears to be a good example of a recurring, symmetrical, erythematous eruption, in direct connec-

tion with catarrhal causes. The patient's unusual liability to perspire probably exposed him much more frequently than others to chilling of the surface from damp underclothing.

Mr. H. W. H——, aged 47, of D——, came to me on November 12, 1890, with both hands peeling, and with the statement, "they always do so when I catch cold." The following are some of the facts which I elicited.

It was seven years since the first attack, which had occurred when he was in bed with congestion of the lungs. Although not definitely ill, he had never been strong. In 1872 he had a bad illness, and Sir W. Jenner visited him at D——. Rheumatism was diagnosed, with congestion of the lungs. He was once sent to the Engadine for his health. Any fatigue would bring on diarrhœa. He did not appear to have been unusually susceptible to catching cold, but still he often did so, and the attacks were severe.

The attacks were described as beginning by redness on the neck in a sort of collar, and then after a few days the hands also became red, and the epidermis would die and exfoliate. Transverse ridges across the nails always marked the dates of the attacks. His impression is that the attacks always follow "influenza colds." He is usually left very weak after an attack. Sometimes there is redness in the sides of the trunk, but no peeling follows there. Last September, two months ago, at Swanage, he had a bad attack, one of the worst he had ever had.

His attacks take about a fortnight, and the present one began a fortnight ago. He never before had two attacks so close together. He had always been a very free sweater; the slightest exercise would throw him into perspiration. He did not think that weather influenced the attacks. He suffered much from debility, but his circulation was good and extremities never cold.

I saw Mr. H—— for a second time a month later. I had prescribed Pearson's solution of arsenic and tincture of belladonna, with cod-liver oil. It had made him dry in the mouth, and he had not therefore taken it quite regularly. He has *had no attacks of peeling* of hands, and has been better on the whole. Has been in better health, and has had no colds. He had a single spot of gangrenous herpes on his forehead, due, no doubt, to the arsenic.

Case III.—*A recurring erythematous eruption on the hands and feet in definite association with catarrhal causes.*

Miss S——, a lady of 28, was the subject of a slight form of xerodermia. She gave the following interesting facts as to the catarrhal liabilities of her skin:—

"In winter, if I take cold and get a chill, the palms of my hands become red and my fingers tingle. The same occurs to my feet, and from my

palms and soles the redness soon spreads upon the legs and forearms. The redness and tingling last several hours, and then disappear almost wholly, but often come back again next morning. These attacks are always from taking cold, and I often have at the same time sneezing and headache. I am very liable to cold-catching, but if I have running at the nose I do not get the tingling of hands. An attack of ordinary nose cold usually lasts me much longer than one in which the limbs are affected. The causes of the two are, however, the same, such as going into cold rooms or exposure to draughts."

I asked Miss S—— to describe to me exactly what her sensations in her limbs were during an attack. She said it was "as if the whole hand or foot were involved in a chilblain, or had nettlerash, pricking and tingling all over." The parts always became crimson but never vesicated. She had in childhood suffered from what was called "nettlerash." It must be remembered that her skin was congenitally in a condition of slight ichthyosis, which probably explains the absence of vesications. Her skin was, she said, always more irritable when the weather was either very hot or very cold. She disliked extremes.

Case IV.—*A recurring eruption on the hands, possibly of catarrhal nature.*

My friend Dr. C——, aged about 50, consulted me in March, 1867, on account of a curious eruption from which he had suffered on three previous occasions, and which had always disappeared spontaneously after about a fortnight's duration. He considered that the attacks had been attended by some slight symptoms of deranged digestion, but there had been nothing very definite in this respect. As a rule, he had enjoyed good health. The eruption had always appeared on the backs of his hands, but on the present occasion it had shown itself also on the face. When I saw Dr. C——, his face and the backs of both hands were covered by an eruption exactly resembling that figured by Hebra under the name of *Herpes iris*. Some of the patches were as large as a fourpenny-bit, and had raised edges and flattened centres; others were not larger than half peas. None of them presented any actual vesication, but they all looked as if just about to pass into the stage of effusion (abortive vesicles). Dr. C——'s attacks had occurred at intervals of a few months.

CASE V.—*Symmetrical eruption of Erythema patches with abortive vesicles on cheeks, backs of hands, &c.—Patient a young boy in good health—A first attack.*

I much regret that my notes of the following case do not enable me to do more than describe the first attack of what was not improbably a recurring malady. I possess a portrait of the boy.

On March 19, 1872, Mr. Tay sent to me a lad whose case presented some very interesting features. The eruption had come out suddenly, three days before, on his cheeks and the backs of both hands. Subsequently groups of spots had covered both ears, and had also shown themselves on the lips and on the neck, in the latter positions only sparingly. During the last day symmetrical patches had appeared on the inner sides of the knee joints. Thus the symmetrical arrangement and preference for peculiar positions was very marked. The rash consisted of groups, irregular in shape, of abortive vesicles, with much surrounding erythema. They were not shaped like the groups of herpes, but most of them were nearly round. On the margin of prolabium of upper lip were some, however, not distinguishable from herpes. None had as yet formed any fluid.

His mother reported that "every morning it was much worse, spreading fast." She could assign no cause. The lad was in good health, and had not in the least lost his appetite. The rash was reported by the boy to itch a good deal, but it had not kept him awake at night.

The boy's name was George Flynn, æt. 8.

CASE VI.—*A Vesicating Eruption on the hands — Relapsing through thirty years—Occurring in no other parts, and usually undergoing spontaneous cure.*

On December 13, 1867, a married woman, apparently in good health, attended on account of an eruption in the palms of the hands and between the fingers. The eruption showed large vesications, some of them as large as shillings, and with a certain amount of inflammatory swelling of the whole hand, back and front. The vesications would usually quickly break and dry up, leaving large denuded patches. In the palms of the hands these patches could not be distinguished from psoriasis palmaris, but on the fingers they were more like eczema.

On the sides of the fingers there were numerous little

minute vesicles, which tended rather to dry up than to break, and resembled the sago grains of cheiro-pompholyx.

Her history was that she had been liable to the eruption for thirty years. The first attack was at the age of 20, two years after her marriage, and she had had numerous attacks at irregular intervals since. She had attended twice before at the hospital, the last time four years ago. She had not observed any connection of the attacks with lactation. She had had a family of fourteen children, of whom nine were living. The attacks did not appear to have been connected with any special time of year. She complained that when the eruption was coming out she was usually very low-spirited. When the attacks were slight they usually got well spontaneously, but on several occasions they had lasted for two or three months, and required treatment. Her current attack was one of the severest she had ever had. It had never occurred on her feet, and had never passed higher than her wrists. She lived at Hackney. I advised a long course of arsenic.

CASE VII.—*Vesicating Erythema ("Erysipelas")—Many attacks during several years—Face, feet, and upper extremities affected.*

A stout, very florid woman, aged 35, attended at Blackfriars in 1875 on account of an eruption of small bullæ on the right foot, leaving small ulcers in a group on its inner side. Her statement was that she had been liable to the eruption on her feet on and off for four years. Usually it would get well after a short time, but it has now persisted for three months or more. Sometimes it had affected both feet at once, but usually only one. She had also often had similar spots (vesications, which would fester and become crusted) on her arms, and she now showed us some small scabs in front of each elbow.

The point in her case which chiefly excited my interest was her statement that she had for eight years been liable to attacks of "erysipelas on the face." Her description of these attacks was that they usually began by itching in the upper lip and burning in the cheeks; that next a few pimples would appear, and then watery bladders, "just as if I had been scalded," which would run a good deal. After a few days the attack would subside, and in the course of a fortnight she would be quite well again. Six or seven such attacks usually happened in each year. Her first attack had occurred eight years ago, during very cold weather, and apparently from washing her face in cold water after unusual exertion. The next morning her face was scarlet, and "little bladders" formed.

She was naturally florid, and was very liable to flush after meals. She had symmetrical patches of lichen-eczema on each side of her neck. A definite feature in the eruption had been its tendency to spontaneous recovery. The trunk had never been affected, nor the thighs or legs. She had never been able to connect the attacks with changes of weather or errors in diet.

CASE VIII.—*Recurring Cheiro-Pompholyx, possibly of catarrhal origin—Patient a married woman, in whose family some peculiar forms of Eczema had prevailed.*

The following case may serve as a good example of the difficulty or impossibility of making a diagnosis between acutely inflamed eczema of the hands and cheiro-pompholyx of neurotic origin. It is unquestionably an instance of an eruption which tended to spontaneous recovery and was liable to recurrence after an interval, and in this it differed definitely from common eczema. It showed also a very marked tendency to the production of "sago grains" deeply placed in the skin. On the other hand, many of its vesications were very small, like those of eczema; it never developed the large bullæ of cheiro-pompholyx, and although it got quite well, it did not do so quickly. I am inclined, however, definitely to separate it from common eczema, and to believe that it was not of local origin, but depended upon a nerve cause.

Mrs. C—— was a young married lady, æt. 26, of dark complexion, and, as she averred, in excellent health. She would not admit that she was nervous, or that she had ever suffered from any depression of spirits. She consulted me on February 20, 1885, with her left hand much inflamed. It was, she said, her third bad attack, but she had often been slightly threatened. The eruption always restricted itself to her hands; she thought that over-fatigue had some influence in producing it. The first attack occurred soon after her first confinement. The left hand was almost always the worst. The eruption usually began by crops of little vesicles between the fingers, which soon coalesced, when the whole surface became vesicated. From the fingers it would extend to the hands, but it had seldom passed much above the wrist. When Mrs. C—— came to me the fingers were all sore and peeling, as if they had been scalded, and crops of vesications just like those of slight scalds extended from the fingers to the hands. Many of the vesications had exceedingly delicate layers of epidermis over them. There were no large bullæ, nor any definite "sago grains." The other hand was scarcely affected, there

being only a few little vesicles between the fingers. The eruption had been coming out for ten days, and Mrs. C—— could assign no local cause. I prescribed a saline, and directed that the fingers should be carefully wrapped in a lead and spirit lotion.

On February 26, a week later, the fingers were very much better. There had developed, however, on both hands and wrists, a number of isolated large "sago grains." These were deeply placed, and occurred chiefly in the palmar surfaces. Mrs. C—— thought that they had been caused by the irritation of the applications; but this was scarcely likely, for they were abundant in the right hand, to which no lotion had been applied.

The following note was made a week later:—Mrs. C——'s case has assumed a fresh phase, the eruption being no longer confined to the hands. When I last saw her there were a few spots on the face, but they were of doubtful nature. To-day there is a copious eruption all around the lips and mouth and on adjacent parts of cheek. These are chiefly erythematous spots and patches, and none are distinctly vesicular, but some are acuminated like abortive pustules, or even a little resemble the sago grain. At the same time fresh crops have come on the hands, even on parts which had seemed to be getting well, and the eruption has spread higher up the wrists.

It should be stated that I had formerly treated Mrs. C——'s sister, Miss B——, for "eczema." I looked up my notes and found some important facts as to family history. Miss B—— was under my care in the latter part of 1874. She had been the subject of eczema from infancy. It had affected the popliteal spaces, elbows, fingers, and wrists, and was now mainly a dry intertrigo. Her father was said to have had the same from infancy till eighteen, when it left him. Most of her brothers and sisters had suffered from eczema in infancy, on the scalp chiefly. Miss B—— told me that her eruption was always worse in cold weather. Latterly it had been most severe in her hands, the thumbs and forefingers especially. Her nails had become rough. Under treatment she got quite well, excepting some little spots on the thumbs. She was obliged to wear wash-leather gloves in the house in cold weather to prevent relapses.

(To be concluded.)

A PECULIAR FORM OF PARALYTIC DEMENTIA IN CONNECTION WITH INHERITED SYPHILIS.

On page 401 of my work on "Syphilis," there is a commentary with the title, "On the comparative rarity of diseases of the nervous system in inherited syphilis," and I had on several occasions previously asked attention to the fact, that as compared with the acquired disease, we but seldom see disorders of brain or spinal cord in those in whom the taint is congenital. I had from the first admitted that a few such cases do occur; indeed, I had myself published several. More recent experience has not led to any material modification of my first opinions. Although there has been a considerable increase of the facts at our disposal, and although many observers have recorded cases, yet the results obtained even by those who were inclined to think that I had understated them, have not led me to feel that I had erred much. After all it is only a question of degree. Undoubtedly the subjects of inherited taint are liable to all the disorders, whether due to inflammation, degeneration, or arterial obstruction, which may occur to those who have themselves acquired the disease. The zealous search of many enjoying excellent opportunities has, however, failed to show that paralysis, idiotcy, dementia, and epilepsy are other than very rare in association with inherited taint. It was in the year 1858 that I visited the Earlswood Asylum for Idiots, in company with Dr. Hack Tuke, with the object of ascertaining whether any large number of the inmates showed signs of taint. Since then, Dr. Hughlings Jackson, Dr. Fletcher Beech, Dr. Judson Bury, and Dr. Shuttleworth have all made very valuable contributions to our knowledge of the subject.

I have to record to-day two cases which support the view

that there is a form of paralytic dementia which sometimes sets in from the age of three to six years, and is rather rapidly aggressive. Under it, a child of average intellect up to the age mentioned, and wholly free from paralysis, may be, in the course of two years, reduced to a condition of the most helpless idiotcy. The symptoms suggest that it is an affection of the cortex, and very possibly of the pia, and that the changes are of a degenerative nature. Not improbably some transitory stage of congestion precedes the degeneration, but there are none of the more severe head symptoms, pain, convulsions, &c., which usually attend the presence of gummata. As we know that there is a form of aggressive choroido-retinitis, peculiar to inherited syphilis, which closely simulates retinitis pigmentosa, it seems not unreasonable to suspect that similar changes may occur insidiously in the grey substance of the cortex. This, however, is only hypothesis for the present.

Case I.—*Congenital Syphilis—No infantile symptoms—Good health till the age of four—Aggressive General Dementia—Choroido-retinal degeneration simulating Retinitis Pigmentosa.*

The subject of the following case is a tall child, aged eight years, emaciated, and of pale, leaden aspect. She sits on her nurse's knee with her spine bent and "in a heap." Her head is usually turned to her right shoulder, and she constantly rotates it. Her mouth is always open, and she often lolls her tongue out, like an idiot. She frequently utters a sort of exclamation. She appears to take no notice of anything, but if for a few moments her eyes become fixed on anything the rotation of her head ceases. Up to four years of age she was quite well. She could then walk well and talk freely. A photograph is brought to me, which shows her a healthy-looking child without anything in physiognomy indicative of syphilis. Her ailments came on gradually. It was first noticed that her left ankle seemed weak and would bend over. After this both legs got weak, and she would easily fall. At the end of a year from this time she had ceased to attempt to save herself with her hands, and would fall on her face. Her speech began to become indistinct, and was gradually lost. At present she

never says more than "mamma," and one or two other short words.

There is not the slightest disorder of nutrition in any part. She never attempts to feed herself or help herself in any way. She sleeps well, and much in the day. She has no playthings, and takes no notice of anything.

She does not easily cry, and appears to be quite good-tempered. She did not resent the striking of her knees or the putting of drops into her eyes.

It is thought that she can distinguish her mother from her grandmother, but with one single exception a year ago, when she suddenly said "papa," her father thinks that she has not recognised him for three years past.

Any sudden noise throws all her limbs into spasmodic movement. Her limbs are exceedingly thin, and none of the muscular masses show up. Her elbows are always bent, and the fingers usually flexed strongly into the palms over the bent thumbs. They can, however, easily be straightened, and in sleep I am assured that the limbs are always quite limp and straight. Her feet are in a condition of talipes equinus, with some varus in the right one. The knees are bent and the flexor tendons tight. If she likes to resist, it takes much force to straighten her knees. The tendo Achillis is tight. Her extremities are very prone to become cold, even in hot weather. The knee-jump is at least normal. Her pupils are of equal size and small. She often turns the eyeballs upwards, but they do not oscillate, and she has no squint.

She can cry and shed tears, but does not do so freely. Her bowels are very costive, and she will often pass a week without any action. She often wets her bed, whereas before the beginning of her symptoms she was remarkably cleanly. Sensation appears to be normal, and she certainly felt tickling of her feet.

The ophthalmoscopic examination was difficult, as the head had to be forcibly fixed to prevent constant rotation. The pupils, small at first, had dilated well with atropine. The media were quite clear. In both eyes there was a broad peripheral zone of choroido-retinal disease, denoted by closely-placed roundish but not abruptly defined pigment accumula-

tions. The retinal vessels were so small that they could with difficulty be found. In the left eye I could not find them even on the disc itself. Of the discs I obtained only momentary glimpses. They were homogenous, hazy, and of a pale pinkish cream tint. Their margins were well defined, but there was an approach to the condition sometimes described as waxy.

It was impossible to estimate the child's vision or her hearing. My impression was that both faculties were very dull indeed. The eyes were but very rarely fixed on anything, and she never took notice of special objects. Any sudden noise made her start, but it was necessary that it should be very loud.

It is to be noted that although her muscles were so small in bulk they were very strong. When she chose to resist, it required much force to straighten her limbs or to fix her head. Her father had to use his strength to keep her head still during the ophthalmoscopic examination. She very rarely shut her eyes, and during my long attempt with the ophthalmoscope I had no difficulty whatever on that score. She kept her eyes constantly wide open. It would seem that her pupillary reflexes were normal, and the iris in full activity, for the pupils were small, and they dilated rapidly and fully under atropine.

As regards the diagnosis of inherited syphilis, there was nothing conclusive in her physiognomy or teeth. The latter were a little suspicious, however, and there were bosses in the frontal eminences. She was very small when born, but had no special illnesses in infancy.

Mr. J——, the father of the child, who came with her, gave me the following conclusive facts as to the syphilitic history. Nearly two years before the birth of the child he contracted, by an accident, a specific sore. Having no suspicion as to its nature, he unfortunately infected his wife, who had both a local sore and an abundant eruption. She required a long treatment, and even at the present time has some skin disease remaining (lupoid ?). The husband himself never had any secondary symptoms, but had throughout good health, and at the present time appears to be very robust.

Although the dates cannot be fixed with exactness, it is probable that this child was born within a year or two of the syphilis in both her parents. It may be mentioned that during infancy the patient was treated with mercury.

The following is a statement of Mrs. J——'s pregnancies:—

1. The patient. The only one living.
2. Premature.
3. Premature.
4. Born dead.
5. Born dead.
6. Born dead.

Had it not been for the father's statement, I should have felt some doubt as to the existence of inherited taint. There can, however, be no doubt that the child is tainted, when we remember that both parents had suffered not long before her birth. There would appear to have been entire immunity from symptoms up to the age of four, and then a setting in with unusual severity of those atrophic changes which accompany the choroido-retinitis which simulates retinitis pigmentosa, and which produce conditions approaching idiotcy. It is probable that the retinal changes represent others, much more extensive, in the grey matter of the brain itself.

Case II.—*Congenital Syphilis — Fair health, but defective development of mental powers—At the age of six aggressive Idiotcy—Raynaud's phenomena.*

The following case may very suitably accompany the preceding. It is an example of exactly the same form of disease, but has not as yet reached the same development. We have a child born of syphilitic parents suffering mildly from the usual symptoms in infancy, but afterwards, although of distinctly delayed development, enjoying fairly good health until the age of six. From six onwards to the present date (four years) there has been aggressive disease probably affecting the cortical substance of the brain, and producing general paralysis and idiotcy. With this a most remarkable enfeeblement of circulation has been produced, attended with Raynaud's phenomena in a severe form.

Dr. G——, who sent the patient to me, wrote that he

knew that the parents and their children had suffered from syphilis. The following are the notes which I took.

R. J. L., æt. 10. Parents marriage fourteen years ago. Both parents suffered soon afterwards from syphilis.

1st, M. Dead, born at seven months.

2nd, F. Died at birth.

3rd, F. Lived to nine. Had affection of spine. Died.

4th, M. 10. The patient. A beautiful baby till five weeks old. Thrush badly. Convulsions at eleven months. No eruption remembered.

5th, F. Died from meningitis, aged nearly two years. One side paralysed. Symptoms of five months' duration only, and believed to have been caused by exposure to the sun.

6th, F. 7. Living, and healthy and intelligent.

7th, F. 4. Living, healthy.

8th, M. 3. Living, healthy. Had convulsions with dentition.

The mother's expression was: "All my children have had thrush, and badly. The thrush came out on the lower part of the body, and the mouth was sore."

Our patient could not walk until two years old. After that could walk and run well up to the age of six. Next it was noticed that his circulation was very feeble. One winter "an ear was caught," and a portion of it sloughed. His hands and feet would become blue, and "black knots" would form on the hands. No sores occurred. He never had anything called chilblains. His youngest sister has also suffered from cold hands. Their mother is a chilly subject. Her fingers in cold weather are apt to become numb. She never has chilblains.

It is about two years since he began "to fall about." He has now lost power in both hands and legs. He can only manage to stand, holding by the table. Last summer he could just walk alone; now he cannot walk at all. He has suffered from constipation all his life. It has been extreme. He never had power in his hands to write. He used to attend a Kindergarten, and liked it, but they found that he could not make strokes in letters. He never quite learned to read. He could talk well formerly, and repeat poetry, though always "childish for his age." Now he cannot speak so as to be understood by a stranger. He is unwilling to speak at all,

and never voluntarily moves himself. He sits with playthings in his hands, but does not play with them. His mother has to turn him over in bed, or he would always lay as at first put. He is rather stout and flabby. At home he is usually sallow and with sunken eyes; but when excited, or opposed, his cheeks become brick-red or dusky. They were very red when I saw him. Recently ulcerations have formed between his toes. He never perspires, and when his feet are livid they are very dry.

He sleeps fairly well. The paroxysms of coldness of hands and feet occur every day, and often several times in the day. His nails and fingers go quite black. The lividity extends half way up the calf. Sometimes the condition lasts most of the day. Usually it begins about three in the afternoon, and lasts till he gets to sleep.

We have here a well marked example of Raynaud's phenomena, and it is to be noted that they have been developed in association with advancing cerebral disease. It must be remembered, however, that the tendency was probably inherited, for both mother and a sister have shown it in slighter degree.

Dr. Shuttleworth, writing from his experience at the Royal Albert Idiot Asylum, has drawn attention to the fact that in some of the cases in which congenital syphilis is the cause, the children were healthy and intelligent during the first few years of life. His cases would some of them, indeed, appear to have been closely parallel to the two which I have here recorded. It is quite in keeping with what we know of some other phenomena of inherited taint that the occurrence of the symptoms should be delayed. The keratitis and the deafness, which are not uncommon, both of them usually set in at an age approaching adolescence. The same statement is especially true of the cases of aggressive choroido-retinitis with pigmentation, which are probably still more closely related to our subject.

ON A CASE OF FATAL HÆMATEMESIS.

I was consulted about ten years ago by a middle-aged member of our own profession on account of extensive tertiary ulceration on his foot and leg. He had suffered from syphilis twenty years previously. He looked extremely ill, and as if not likely to live many weeks. He was very pale, and had been liable to vomiting of blood. His liver was not much enlarged, but could be distinctly felt to be hard and nodular. He did not take nearly so serious a view of his case as I did, being of a very cheerful temperament, and alleging that he had often been very ill before. He was at the time quite confined to his bed. I prescribed for him the three iodides, in a mixture, with a calomel pill; and under their influence he made the most astonishingly rapid and complete recovery. Within a few months he was again engaged in a laborious country practice. He remained under my observation at intervals of six or twelve months for the next eight years. During this time he never had any recurrence of his syphilitic ulcerations; but he suffered repeatedly from attacks of the most profuse vomiting of blood. These attacks occurred over and over again, and in more than one it was feared that he would die. I have never seen any one survive who presented a condition of bloodlessness equal to that which he showed on several occasions. His attacks of blood-vomiting would come on quite suddenly when he was not feeling ill. He assured me that the blood would pour forth from his mouth so that a large basin would be filled in the course of a quarter of an hour. On several occasions it had been necessary to leave him on the floor for the night, for fear that any movement might be fatal. Usually these attacks were over in the course of half an hour; but on more than one occasion they recurred during several days. As he lived in the country, I never

myself saw him during an attack of bleeding. The medical men who were called in to him always diagnosed ulcer of the stomach, and there seemed no other explanation of such profuse bleeding. Against that suggestion, however, there were the facts of long-continued liability, and an entire absence of stomach symptoms. There had never been any pain in the stomach, and as soon as ever the attacks were over Dr. I—— would begin to eat meat freely and to take port-wine in order to make up the blood he had lost.

The rapidity with which Dr. I—— recovered was most remarkable. He was an exceedingly plucky man, and a fortnight after an attack which had brought him to death's door, and made him look like the corpse of one who had been bled to death, he would be going about as usual and visiting his patients. In addition to the attacks of hæmatemesis he suffered also repeatedly from ascites. His abdomen would become distended until he could only just manage to walk about. Calomel was the remedy for this state of things. The ascites and the vomiting of blood generally occurred together; and the calomel, when given in conjunction with tincture of iron, so far from increasing his anæmia, seemed to help the process of blood-making. On one occasion, after a very severe attack, I had sent him to Brighton to recruit, and there his ascites became so distressing that he wrote to ask me to come and tap him. The next day, however, he was better, and within a fortnight, his gums having in the interval been a little sore, the fluid had almost wholly disappeared.

At length the end came. He had been attending to his patients as usual, and thought himself in better health. After having complained to his wife of a sense of weight at his stomach, vomiting of blood set in, and was so profuse that death resulted. I did not hear of the event until a week afterwards, and unfortunately no autopsy had been performed.

I have found in an old volume of the Dublin Hospital Reports a case which seems to supply what my narrative wants—post-mortem proof that this form of hæmorrhage may prove fatal, although no ulcer of the stomach be present. A man of 24, a tailor, was admitted under Dr. Cheyne's

care in an exsanguined condition from hæmatemesis. He had been ill only four days. He looked like a spirit-drinker, but he denied that such was the case, and said that a year previously he had suffered from a similar attack, and had almost died from it. In the interval and formerly he had had good health. During the three weeks that he was under Dr. Cheyne's care in the hospital ascites developed itself. Further vomitings of blood took place to the extent, on one occasion, of "four large basinfuls," and the stools also contained the remains of blood. After one of these attacks death took place. The post-mortem revealed a bloodless condition of all viscera, and mottled kidneys; but there was no ulcer in the stomach. The left lobe of the liver was enlarged and indurated.*

During my poor friend's life we often discussed the question as to the source of the hæmorrhage, and were much puzzled to give any plausible explanation. That he was the subject of cirrhosed liver was undoubted; but the attacks were more sudden, more profuse, and more easily recovered from, than any which I have ever supposed to be explained merely by hepatic impediment. Since his death it has occurred to me as not at all improbable that he was the subject of varicosities of the lower œsophageal veins. For the reasons already given, it seems improbable that he had an ulcer of the stomach, yet the bleeding far more nearly resembled that of an open artery or vein than anything that we can suppose possible from mere congestion. The fact that the veins of the lower part of the œsophagus do become varicose, and are sometimes the source of fatal hæmorrhage, has been established by clinical observations which have been placed on record. I possess a French thesis by M. Eichhorst, recently published, which gives a detailed account of their anatomy and a summary of the cases previously recorded. The anatomical arrangement of these veins is such that they tend to dilate, as collateral channels, whenever the circulation through the portal vein or liver is obstructed.

An excellent paper on this subject was read at the Bir-

* A Case of Melæna, with Observations, &c., by J. Cheyne, M.D. Dublin Hospital Reports, vol. i., 1818.

mingham meeting of the British Medical Association in 1890, by Dr. Stacey Wilson and Dr. J. R. Radcliffe.* The first case published in Britain appears to have been one by Dr. Bristowe, in the Pathological Transactions. In this case it was specially noted that the liver was healthy, although the patient, a woman of 48, had suffered from ascites. She had died in her first attack of hæmatemesis. The vein which had bled was recognised at the autopsy. In the paper to which I have referred Dr. Radcliffe records five cases, several of which are very complete. He concludes his paper by expressing the belief that, if pathologists would look for these ulcerated œsophageal varices, they would be found much more commonly than is supposed, and that the theory of "capillary oozing as a cause of hæmatemesis would gradually ooze away." In one of Dr. Radcliffe's cases it is stated that the blood rushed from the mouth of the patient "as from a hose-pipe." He brought up on one day eighty-four ounces, on the next forty-eight, and on the day following forty.

A paper was read at one of our Medical Societies some years ago by Dr. Donald Hood on "The Hæmatemesis of Early Life." One of its main objects was to discredit, by post-mortem facts, the too prevalent belief that profuse and fatal bleeding from the stomach necessarily implies the existence of an ulcer.

As an illustration of the profuseness with which bleeding may occur from a ruptured varix, the case of a distinguished London physician may be mentioned, who, some years ago, died in his own house, before assistance could be procured, from the giving way of a vein on the surface of the abdomen.

* The patient whose case I have recorded above died before either this paper or the Paris Thesis were published, and I had not therefore the advantage of being acquainted with their contents.

MUSEUM NOTES.

(*Continued from page* 139.)

A Duplicated Limb with arrest of growth.

A specimen in the Dupuytren Museum, No. 148, is the skeleton of a cock which had been allowed to attain full age and has a strong spur. It has, however, only one, and during life may have ranked as either one-legged or three-legged. It has but one well-formed and complete leg. It is its left. On the right side two large femora articulate side by side with the pelvis, but both end in irregular developments of bones, which have no feet. It is probably an instance of duplication of a member by dichotomy with subsequent arrest of growth. It is described as "Un coq, monstreux; Genre, Ischiomèles." Dr. Duplay.

Deficiency of Ulnar Digits with dwarfing of carpal end of Ulna.

Deficiency of the ulnar digits (a very rare defect) is illustrated by specimen No. 32 (Teratologie) in the Dupuytren Museum. A cast and a skeleton of hand show the little and ring fingers with their metacarpal bones wholly wanting. The bones of the carpus appear to be anchylosed and to consist of two only, or rather three, for the pisiform is quite definite and large. The ulna is well formed at the elbow but is too short and somewhat defective at its carpal end. This has led to much bending of the radius. The three digits which remain are rather long and large, the middle one especially so.

Examples of Arrest of Development of the Spinal Column.

There are cases of arrest of development of the spinal bones which may possibly be the converse of those in which

the limbs are defective. At any rate, it is clear that the laminæ of the spine may be absent in its whole length, and even the cranium absent also, whilst the limbs are well developed. In these cases the spine is usually very short, and, it may be, placed almost horizontally.

In the Dupuytren Museum 90A is an example of a fœtus of the kind described. The head is of fair size, but the trunk is so short and so almost horizontal that the hands touch the feet. 90 shows an approach to the same condition.

85, 86, 87, 88, and 89 show similar states, but in all the head is also very defective.

90D is also a short-trunked dwarf with good limbs.

One-sided Arrest of Development of Limbs.

M. Philipeaux has placed in the museum (it has no number) the skeleton of a hydrocephalic fœtus, which at first sight appears to have only one leg and one os innominatum. On more careful looking, however, a malformed limb with displaced os innominatum is seen curled up on the back. There is a femur and a tibia, much altered in shape, no fibula, no tarsus, and only a single digit. The upper extremities are well formed, but the left is rather the larger, and all the left ribs are much longer than those of the other side, thus displacing the thorax to one side in a manner which I never saw in any other specimen.

It is an example of one-sided defect of development, the defect being slight in the upper limb and trunk but great in lower limb.

Symmetrical Depressions in the Parietal Bones (the so-called Senile Atrophy of the Skull).

In the Dupuytren Museum there are five calvaria which show this peculiar condition, and which are nearly all alike. They are 439, 431A, 439B, 438, and 441. They are described "Atrophie Senile et symétrique de la partie eurilleuse des parietaux."

Three of them show a central furrow passing downwards and backwards between high ridges of dense bone. These ridges separate the furrow from the lateral pits: 439 shows

this in a very marked manner, and it also has several other smaller round pits behind the principal ones.

Skull-caps showing these peculiar depressions are very rare. I have seen them in but few museums. Our own College of Surgeons collection possesses three or more. One of them is from Egypt, given, I believe, by Prof. Flinders Petrie. They are much like those in Paris. These depressions are not like those produced by disease, and they are always symmetrical. It occurs to me, in default of a better explanation, that they are due to wearing some specially adapted form of saddle for the head upon which burdens were rested. The Egyptians were, it is known, much in the habit of carrying on the head, and so are the Parisians of certain callings. The English, Germans, and Scandinavians use the head but little for this purpose. If it be objected to this suggestion that, were it correct, these skulls ought to be much more common than they are, I reply that only a minority of clergymen show well developed "pray-patches," and that although many French street-barrow-men yoke themselves to their trucks, "Psoriasis en bretelles" is yet very uncommon.

Mr. Eve has described the College of Surgeons specimens in the Pathological Society's Transactions, vol. 41, p. 244. Four of those in the Dupuytren Museum to which I have above referred were long ago alluded to by Sir George Humphry in his work on the Skeleton. Dr. Maier has described two which are in the Freiburg Museum. All admit that they are the skulls of old persons, mostly of old women. One of the three in our own College of Surgeons Museum is that of a Wallachian gipsy woman from the Barnard Davis collection. The vocation of the subject in this instance may perhaps give some support to my conjecture as to their cause. It may add to its plausibility if we reflect that it is probably when the habit is continued into old age that it produces atrophy.

I have obtained for my museum some excellent photographs of the Paris skulls.* I find it very difficult, in spite of Mr.

* I have the negatives, and can supply copies.

Eve's ingenious explanation, to believe that the depressions are of spontaneous origin.

The Encrusting Periostitis of the Lower Animals.

I have several times in my ARCHIVES referred to the subject of "Encrusting Periostitis" as it is seen in the skeletons of certain mammalia. Almost all our large country museums contain one or more specimens of it. A few weeks ago I had half an hour in the museum at York, and there noticed the skeleton of a young but full-grown lion which afforded a good example. Almost all the long bones were roughened over by a thin deposit of new bone. The condition is wholly distinct both from rickets on the one hand and osteitis deformans on the other. It consists in the formation over very large areas, or perhaps over almost the whole length of a bone, of a thin deposit of new bone, hard in texture and rough, so as to form small stalactites. In the human subject it is closely simulated by bones which have been inflamed after compound fracture, and sometimes, though less accurately, by syphilis.

The best specimen that I know of is that of an old dog in the museum of the Edinburgh University; but the skeleton of a tiger which stands at the head of the staircase in that of Trinity College, Dublin, affords also an excellent example. Others more or less good I have found in almost every museum that I have recently visited. It would appear probable that the condition is more common in animals which have been domesticated or kept in confinement. Sir William Turner showed me in Edinburgh the vertebra of a whale which suggested similar changes. Unfortunately none of the long bones of this animal were forthcoming.

Mr. Platnauer, the able curator of the York Museum, was good enough to examine the skeleton above referred to more carefully after I had left. He informs me that the bones on both sides are attacked symmetrically, and that the ischium, ilium, and pubes, femur, tibia, fibula, calcaneum, tarsals, and metatarsals are all extensively affected. The humerus, radius, and ulna have also suffered, but less severely than the bones of the lower extremities. The rami of the lower jaw are also slightly attacked on their inner sides.

Nothing is known as to the history of the animal during life. The skeleton is one of many given to the museum by the late Mr. James Atkinson, the learned and witty author of "Medical Bibliography" (1834), and formerly a vice-president of the Yorkshire Philosophical Society and surgeon to the county hospital. It is probably that of a menagerie animal, and its epiphyses denote youth.

The following notes were made on the occasion of a recent short visit to the Pathological Museum of the Leeds Medical College :—

Specimen showing transparency of Gangrenous tissues.

Amongst the specimens in the Leeds Museum there is one showing a condition of transparency of the skin and soft structures of the foot, such as I never saw anything at all equal to. You see through the skin of the digits as if looking through yellow glass, and the forms of the bones can be distinctly traced. Cellular tissue, ligaments, and everything have become quite transparent. The skin is not contracted on the bones ; it is, on the contrary, swollen and tight, as if from œdema. The specimen is mounted in turpentine, and I should have supposed that the peculiar transparency had been produced by that medium, had not Mr. Haigh, the curator, assured me that the condition was almost as marked during the life of the patient, and that the specimen had been preserved on account of that peculiarity. The foot was that of a woman, aged about 47, who had died after gangrene of both legs, in consequence of plugging of both external iliacs. The limbs had become, I was told, almost black about the knees ; but one of the feet, instead of mummifying, had become somewhat swollen, and passed into this peculiar transparent condition. The transparency was greatest on the backs of the digits, but affected more or less the whole of the foot. The nails were opaque.

The gangrene did not occur quite simultaneously in the two limbs. One had been amputated (by Mr. Mayo Robson) a month before the other became gangrenous. It was the second only which assumed the peculiar transparent condition. The notes of the case on the day before the patient's

death describe the foot as "dry, hard, and somewhat swollen." The transparency was such that "the joints of toes, phalanges, tendons, and subcutaneous vessels were clearly seen."

Plugging of Aorta with Gangrene of Limbs.

No. 150 in the Leeds Museum is a splendid specimen of plugging by fibrinous clot of the abdominal aorta at its bifurcation and of both common iliac arteries, the patient having died of gangrene of the legs.

Peculiar condition of Skin in fœtal Pigs.

I was interested in observing the state of the skin in two fœtal pigs, which had been preserved on account of malformation of the head—in each case, I think, the cyclops condition. The skin of the back and sides of the animals was, in each instance, pitted over with shallow depressions of various sizes, and none larger than a split pea, most of them much less. The rest of the skin was plump and smooth. It is often observed that animals, which are malformed in one structure, exhibit at the same time defects in others which are apparently quite unconnected. The little cicatricial pits were arranged symmetrically on the two halves of the body, and the animals, so far as my cursory examination went, showed no other malformation.*

Hydrocephalus in a Calf.

No. 215 is the skull of a calf showing congenital hydrocephalus. The cranial cavity is of enormous size, and the bones are thinned out in the most extraordinary manner. Unfortunately craniotomy was necessary in order to effect delivery, and thus the opportunity for dissecting the brain was lost. Although the condition is a rare one, it is not, I believe, so infrequent but what some zealous young surgeon, enjoying a certain amount of leisure in country practice, might, by making interest with the veterinary surgeon, procure a specimen for careful dissection.

* Mr. Haigh has since been good enough to examine these pits carefully. He believes that they represent gland orifices and hair follicles, and result from maceration.

Intra-uterine Amputations associated with defective formation of face.

One of the fœtuses, illustrating intra-uterine amputations, is of considerable interest, on account of the different stages of the amputation at the same time in different parts. The right thigh presents a well-healed stump, which has already by continued growth of bone assumed a conical form. Some of the digits, however, constricted at their bases, have not yet dropped off. Two of these, very short, and of which the growth has evidently been arrested, look as if just about to detach themselves; whilst another, of full length and well formed, shows at its base a deep furrow of constriction. The nose in this fœtus presents the curious condition, which we sometimes see, of depression with an almost bifid condition, there being a deep vertical indentation in the lip and nose, as if a cord fastened to an incisor tooth had passed upwards to the forehead. This malformation of the nose is usually coincident with hare lip and cleft palate. I could not ascertain whether the palate was cleft in this instance, the specimen being in a bottle. There is no very obvious explanation of the association of cleft palate with intra-uterine amputation of limbs.

Well-formed Limbs with arrest of development of Cerebro-spinal Centres.

Three partially acephalous fœtuses, with the head thrown back, and the upper part of the spinal canal open (as usual), illustrate the well-known fact that perfection in the development of the limbs is not dependent upon perfection of the cerebral and spinal centres. In all four the limbs were well formed. One of them was the subject of a large hernia; and the other showed the peculiarity of having its body covered with downy hair of very considerable length.

A PECULIAR FORM OF HYPERTROPHIC ACRO-DERMATITIS IN ASSOCIATION WITH GOUT.

The malady which I wish to describe in the present paper is by no means a simple or specific one. Yet it appears to be fairly well specialised, and clinical convenience will, I feel sure, be served by separating it from others. It has alliances —probably essential ones, and not of mere resemblance—with psoriasis, xanthoma, and chilblains, whilst the main cause of its peculiarities is, I think, an inheritance of tendencies to gout. It is not probably a direct phenomenon of active gout, but rather a result of those peculiarities of tissue-tendency which the descendants from several generations of gouty ancestors inherit. Thus it will be seen that the malady in question is one involving, as do many other curious and well-characterised chronic disorders, a very complex partnership of causes. From this it will follow that we ought, in connection with the different shares taken by the several partners in different cases, to expect considerable modifications in the final result. We presuppose peculiarities in the endowments of the skin itself tending to chilblains; of the vascular system, tending to venous congestion; of the liver, giving liability to xanthoma; of the kidneys and digestive functions, giving tendency to gout; of the wholly unknown peculiarity which conduces to psoriasis; and, perhaps I ought to add, in deference to the opinions of some who would claim the malady as "sarcoma," of an inherited tendency to malignant new-growths. Out of such various pathogenetic forces it is obvious that there may be constructed a malady which, whilst in the main well characterised, may yet manifest considerable modifications in different instances. A plum-pudding, to use a

homely simile, may keep its name and its character, though the proportions of plums, sugar, eggs, &c., may vary in different examples. It is, I think, exactly so in the case before us. In some cases there is more of psoriasis and less of chilblain, in some more of gout and less of psoriasis, whilst in some the xanthelasma element may perhaps be wholly omitted.

The conditions to which I refer are amongst the rarities of dermatology. We encounter them at various ages. One group, which I will for the present call the "Judson-Bury Group," * occurs in early life, before any habits of the individual can have done much to strengthen the tendency to gout, and in these we must expect a very decided history of inheritance. In a second group the disease does not begin till past middle life, and occurs to those whose mode of life has conduced to gout. Between these, however, we have other cases in which probably both inheritance and acquisition of gout take their share, and which may begin at any period of life.

As the cases which I have published as examples of this malady are scattered in different works, it may be convenient if I give a brief *résumé* of them.

Case I.—In January, 1869, I first saw John W——, then aged 58, whose case is given with a portrait in Vol. I. of "Clinical Illustrations of Surgery." His patches on his hands had been present two years. He lived ten years longer, and then died, of gouty kidneys, in King's College Hospital. During the whole of this time his disease had continued to advance, the patches increasing both in size and number. They were remarkable for their purple tint. They occurred symmetrically, and, I believe, to the last were on the extremities only. Throughout there was nothing to suggest malignant tendencies. The patches were thick, congested, and consisted chiefly of solid œdema. They were clearly infective in the same manner as psoriasis is so, and

* Dr. Judson Bury, of Manchester, published in the *Illustrated Medical Journal*, 1889, the first good example of this form with which I am acquainted. He was good enough to supply to me some further particulars respecting this patient, which I published, together with a plate copied from his, in Archives, Vol. II. 300. This plate, for the convenience of my readers, I now again append.

they affected some of the regions often attacked by psoriasis. The man had suffered severely from gout during almost his whole life.

Case II.—This I know only from a portrait, having never seen the patient, and no history was to be obtained. The portrait was shown me by the late Professor Boeck in the collection in the museum at Christiania. It represented the hand of a Swedish sailor. I can only say that it was exactly like the hand of my patient, and that I have no doubt whatever as to its being an example of the same malady.

Case III.—Mr. B——, a florid farmer, aged 65. He had been for some years (five at least) the subject of symmetrical patches of a blue or livid colour, which were confined to his limbs. They occurred symmetrically, and affected some of the psoriasis positions, but were not restricted to them. Extensive induration of the cellular tissue had been produced in connection with the patches; there were many dilated venules, and, as a peculiar feature which I have not seen in other cases, must be noted little subcutaneous cords (veins or lymphatics) which ran up from the patches. Two injuries to the shin, one a severe wound, were supposed by the patient to have had some share in exciting the disease. He was a man very likely to have had gout, but I am sorry to find, on reading my record of the case (see *British Journal of Dermatology*, vol. i. p. 8), that I have omitted to record the evidence which I cannot doubt that I obtained.

I will leave aside several cases in which I have seen the early stages of this malady, but in which no development occurred under my observation which would justify a positive diagnosis. I suspect that gouty men not unfrequently show these patches for a time, and that the affection is by no means an incurable one in its early stages. As in so many other maladies which are accounted rare and very peculiar, it is probably only a minority which we recognise and name—those, to wit, of severe form, long duration, and with pronounced aggressive tendency.

I will now pass to the cases which occur in younger persons, and in which the *inheritance* of gout is to be suspected. These I will for the time venture to call

The Judson-Bury Group.

Case IV.—Dr. Judson Bury's own case will be found in the *Illustrated Medical News* for May, 1889, and it is recapitulated with additions at p. 300, Vol. II. of my Archives (see portrait LXI.). Its subject was a girl twelve years old when the sketch was taken, and now seventeen.* The parts affected, in addition to the hands and feet, were the psoriasis positions, and the disease showed accurate bilateral symmetry. It was slowly aggressive, and I believe is so up to the present date, but whilst some patches have increased, others have disappeared. The patient, a girl, is still in good health. She has herself had an illness which was called rheumatic fever, but it is not known that she inherits gout.

I will now relate two which have come under my own observation recently, and which constitute my reason for writing the present paper. They are very definite examples of the malady in question, and in both the history of family gout is very strong. It is also in connection with their history that I feel justified in introducing the element of feeble circulation and chilblains as an important ingredient in the causation of the phenomena. In the first of these the disease began not on the hands, but on the elbow tips.

Case V.—Miss U——, now aged 20, was brought to me by Dr. ——. She had not suffered from any particular disease, excepting quinsy, until her present malady began about eighteen months ago. The first symptoms were patches on her elbows. Her hands soon after became affected with little indurations in the skin, and she had patches in the psoriasis positions on the fronts of the knees. A lump also formed on one heel. Thus far the elbows, hands, and one heel have been the only parts affected. She was one of twelve, all living. Two had suffered from infantile jaundice.

The family history was of strong inheritance of gout, and of tendency to torpid livers. Many members of the family had suffered from the latter. Her paternal grandfather had

* The earliest example of the disease in the adult with which I am acquainted is that given in my "Illustrations of Surgery," p. 42, Plate VIII.

"died of gallstones," having previously suffered from jaundice.

Present Condition (Nov. 20, 1890). On the elbows and knees there are groups of ill-defined papules on a congested base. On one knee there is but little more than a patch of congestion, the tubercles being very ill-marked. On the heel there is only a patch of inflamed skin, such as might have been caused by chafing. It is just over the attachment of the tendo-achillis. The hands present conditions which are almost symmetrical; lumpy and nodular thickenings are seen under the skin of all the fingers. Some of these lumps are quite isolated, glossy and semi-transparent, but others are more deeply placed and less defined. The ring fingers of both hands have almost wholly escaped. The symmetry is not, however, exact, for in the left hand the middle, ring and little fingers have almost wholly escaped. In the right hand the little finger is severely affected. The right thumb, middle and index finger, and left index finger are those most affected, and in these the subcutaneous nodules are so numerous that they are almost confluent. None of the nails are in the least involved. In each hand a patch passing up from the base of the palm to the index finger is very conspicuous. In the left hand, on the ulnar border just above the wrist is a large thick induration which has no representative in the other. There is no yellow xanthelasma deposit in connection with any of the growths; excepting that this feature is absent, they resemble what is seen in tuberous xanthelasma. Miss U—— says that they frequently burn and smart. She has recently been advised to take port wine, and says that it distinctly makes the lumps worse. Miss U—— is a tall, well-grown girl, but pale and of somewhat feeble circulation. Her case is evidently a partnership of tendencies to gout and xanthelasma, with possibly a tendency to psoriasis also. The nodules are somewhat like those described as rheumatic nodules, but they become much more superficial and cutaneous, like those of xanthelasma. They are in the positions, in part at least, which are affected by psoriasis and also by xanthelasma. The severity with which her fingers have suffered must probably be attributed to her feeble circulation.

Fig. 1.

Fig. 2.

Remarkable disease of Hands.
(Copied from Dr Judson Bury.)

West, Newman, lith.

On January 18, 1894, this patient was good enough to attend one of my demonstrations at the Clinical Museum. During the three years which had elapsed her condition had undergone but little change.

Case VI.—Mr. R——, a healthy man, aged 25, sent to me by Dr. White, of Nottingham, was the subject of a very peculiar eruption which affected the psoriasis positions, and in addition his ears and fingers. Yet it was nowhere like psoriasis, the patches consisting of aggregated little tubercles which desquamated but did not form scaly accumulations. On his ears, both helix and anti-helix, there were a number of conical whitish tubercles, deeply placed, and which might easily have been mistaken for tophi. They were, however, not tophi, but of fibroid structure. The whole ear was dusky and thin. His right hand was more severely affected than the left, but both hands showed many papules and nodules arranged more or less in groups. Some of these were very ill-defined, but others, having become confluent, had formed distinct rings. They were attended by a certain amount of infiltration of the subcutaneous tissue, and were of dusky colour. Most of them were smooth on their tops. They were very painful if struck, but not otherwise. He described their development by saying, "A little nodule forms first, which scales and then dies, and others form around it and thus make circles." His face was quite exempt, but on both elbows and on both knees there were confluent groups of smooth tubercles. The patches appeared to be spreading at their edges, and those on the knees, although very near to them, were not exactly on the psoriasis positions. The history which he gave was that it was three years since the first patch appeared on his right hand. For some time before that he had been suffering from warts on the hands, to which he had been applying caustics. This eruption followed the warts, and, as he thought, had been caused by them. For about a year the spots on his hands made but little progress, but for two years past they had been almost in their present condition. He had been travelling in India and Australia, and during the whole of these two years had never been exposed to winter cold. He was a tall man, of clear, good complexion, and had never

suffered from syphilis. From his father he inherited a feeble circulation, and his maternal grandfather and great-grandfather had both suffered severely from gout. His mother was the subject of chronic rheumatism. He stated that he had been born in Nottingham, and that he had enjoyed good health as a boy, though liable to biliousness and always sleepy in hot weather. His skin did not appear to be especially affected by the sun. He stated that he browned well and never blistered. He thought that neither heat, cold, sun, nor wind had any influence on his eruption, but in cold weather his hands and ears easily became numb. The coloration of his cheeks was somewhat patchy. His pulse was of good power but slow—64. The patches were undoubtedly spreading serpiginously. Some of them showed a tendency to form large circles. No definite scar was left where the condition had subsided. The borders of the patches were made up of a number of crescents (aggressive). The peeling was more like that of lupus exfoliativus than of psoriasis.

Case VII.—Of this case I have seen only a portrait. It was shown me by Dr. Radcliffe Crocker. I was at once struck by its close resemblance to Dr. Judson Bury's case. It was that of a young person, and Dr. Crocker subsequently told me that there was a clear history of gout.*

I have yet several other cases to narrate which bear upon this subject, though not exact parallels to those which I have given. One of them shows the coincidence of xanthelasma, and justifies, perhaps, more than any of the above my plea for the admission of a tendency to it as being one in the partnership.

* Since this was in type, Dr. Crocker has published his case, with a good portrait, in the *British Journal of Dermatology*.

TWO FATAL CASES OF OBSTRUCTIVE JAUNDICE.

The two cases which follow are of much interest as illustrating the symptoms which may attend obstructive jaundice from irremediable cause.

Case I.—*Sudden onset of illness with Abdominal pain, Jaundice and Purpura—Jaundice persistent until death in the eighth week.*

I saw with Dr. Reynolds, of Stamford Hill, on Saturday, Jan. 7, 1893, a very interesting case of obstructive jaundice. The patient was a young man of twenty, standing at least six feet high, and habitually thin. He had some slightly enlarged glands in the neck and in the groins, but they had never given him any trouble, nor had he before his present illness regarded himself as especially delicate in any way. He had been about five weeks in bed with persistently high temperatures, increasingly deepened jaundice, bile and albumen in his urine, and entire absence of bile in his stools. His illness had commenced with what was supposed to be a catarrhal attack affecting his stomach and liver, and the jaundice did not set in until he had been a week in bed. About the end of a fortnight from the beginning of his illness he had been covered with purpura from head to foot, but without any hæmorrhage from mucous membranes. This purpura did not last long, and it had absolutely disappeared some time before I saw him.

I found Mr. R—— extremely emaciated, and presenting everywhere a deep yellow tint. The tint was slightly brown, but inclining to a lemon-yellow. His tongue was furred with a broad dry streak down the middle. His pulse was quickened and hard; it might, indeed, be described as wiry. I could trace

his radial artery in his emaciated arm with great ease nearly up to the bend of the elbow, and, on my noticing this, his mother remarked that his pulse could be felt anywhere, even by the sides of his fingers. This I found was quite true.

Mr. R—— had been seen in the beginning of his illness by Dr. Goodhart, and later on by Dr. Harley. It appeared tolerably clear that he was suffering from obstructive jaundice, and the question to be determined was as to the probable nature of the obstruction. In order to determine this, I questioned him closely as to the way in which his symptoms had developed. It appeared that he had been seized with pain suddenly one morning whilst walking in the street. The pain was such as to induce him, a few hours later, to leave business and go home. He rested on the sofa, took a little brandy, and then went to bed. On the following morning he was sufficiently recovered to eat his breakfast and go to his office; he returned, however, in the evening, again with pain, and had a bad night. The next day he was seen by Dr. Reynolds, and during the whole of the next week there was very considerable pain over the region of the liver. The pain had, however, at no time been of a very severe character, and was described as aching rather than spasmodic. At first there was nothing to be felt in the abdomen, but more recently the indurated border of the turgid liver had become perceptible. He had never had any "liver attack" before, nor was there any history of gall-stones in his family. One sister had had a slight attack of jaundice.

The abdomen when I saw Mr. R—— was rather swollen, and although tympanitic in front, possibly contained some fluid. I could not feel anything definite in connection with the gall-bladder. The whole region was somewhat tender, and he preferred to rest with his knees drawn up. It seemed to Dr. Reynolds and myself impossible to say whether the obstruction was due to a gall-stone, or to pressure from enlarged glands, or any inflammatory swelling external to the duct. We discussed carefully the question of operation, but finding the parents of the youth very averse to any suggestion of the kind, we did not feel justified in urging it upon them. We agreed that, on the whole, his chance of recovery

was quite as great without it. At the same time we were obliged to give a very doubtful prognosis. It will be seen that there were two or three objects which might possibly be served by operation. First, there might possibly be a gall-stone, which might be removed; secondly, although the cause of obstruction might be irremediable, it might be a gain to the patient to establish a biliary fistula, and thus save him from the poisonous effects of bile in his blood; thirdly, there might be some abscess, the opening of which would afford relief.

It is to be noted that the symptoms attending the commencement of the illness, although they seemed to point to plugging by a calculus, were by no means conclusive; for the pain, although it began very suddenly, had not been persistently severe. I did not see the patient again, but the following letter from Dr. Reynolds supplies the sequel:—

The Elms, 128, Stamford Hill, N.,
March 17, 1893.

Dear Mr. Hutchinson,—The very interesting case of jaundice you saw with me in the early days of January terminated on the 17th of that month, and the result of the post-mortem will be of especial satisfaction to you, as, if you remember, we thought it wise to discard all thoughts of exploration.

The cause of the obstruction was glandular carcinoma of the head of the pancreas, involving by pressure the bile duct and spreading to the mesenteric glands in the immediate neighbourhood. The microscopical appearance of the gland in the groin was of the same nature. The case lasted for exactly seven weeks—no complaint at all having been made previously, though to my certain knowledge the gland in the groin was there before. Evidently he had nothing to complain of until the growth began to press on and involve the bile duct, and then the distress came.

Believe me, yours faithfully,
W. Percy Reynolds.

Case II.—*Case of Prolonged Obstructive Jaundice—Cholocystotomy performed—Malignant Growth—Death.*

I visited Mrs. H—— at her house in Guildford in consultation with Mr. Parson, of Godalming. I had been told that she had been long ill with jaundice and sickness, and that

whilst malignant disease was strongly suspected, it was yet wished that the question of operative exploration should be fully discussed.

I found Mrs. H——, a lady of sixty-one, the subject of deep jaundice. Around her eyelids the tint was almost black, and on all other parts of an intense dark yellow. She had been confined to her bed for about fifteen weeks on account of loss of strength, attended with sickness and entire failure of appetite. Her more severe illness and the setting-in of definite jaundice dated from September, 1891; my visit to her was on January 10, 1892. I had been told that there was distinct fulness over the liver, such as had led to the suspicion of a cancerous growth. The abdominal examination was not very easy, for although she was emaciated and the abdominal wall very lax, it was yet loaded with fat and the muscles were remarkably resistant. It was certain, however, that there was an ill-defined swelling about the region of the gall-bladder, and it was only on pressure at this point that she made any complaint of pain. There was not the slightest ascites, nor had there ever been any symptoms indicating abdominal obstruction. The bowels, which had formerly been very costive, were now acting regularly, but the stools were quite white. The urine was loaded with bile.

Mrs. H——'s history was that she had been through life dyspeptic and bilious, and often very dark around the eyelids. No one had ever suggested that she was the subject of gall-stones, nor had she ever been jaundiced. Although her definite and severe illness had set in only in September, yet for six months before that she had been somewhat failing in health, and, as her daughters thought, had been looking yellow.

One point was perfectly clear in this case—the patient was suffering from some obstruction to the common bile-duct, her jaundice was intense, had been persistent for at least four months, and was increasing. There were several points in the history which appeared to me to point rather to plugging by a gall-stone than to the presence of a malignant growth. Although the patient had failed much in health during her illness, yet I was told that she was not now getting worse; that, in fact, the sickness was much less than it had formerly

been. Two months ago her death had been expected, but since then she had decidedly gained ground a little. The fulness which was present over the liver had remained much as it was from the first, no fresh tumours had formed, there was no evidence of disease in other parts of the abdominal cavity, and the quantity of bile excreted in the urine made it certain that a large part of the liver, at any rate, was still capable of functional activity. The symptoms had in fact been throughout those of bilary obstruction, and nothing more. I was therefore inclined to think that the probability was in favour of the absence of cancer, and that we ought at any rate to give her the chance which an exploration would afford.

A few days after my first visit I explored the gall bladder. It was of large size, being distended by thick bile. It did not contain any calculus. Having ascertained that there was a round hard growth as large as a marble which adhered to the common duct and occluded it, I contented myself with leaving a drainage tube in. The operation gave apparently some relief for a few days, but hæmatemesis subsequently occurred, and the patient sank about a week afterwards. There was no autopsy.

SYPHILIS SIMULATED BY GOUT AND STRUMA.

A group of cases are coming to our knowledge in which conditions occur most deceptively like those of syphilis, and of which the diagnosis is to the last degree perplexing. Thus we have been accustomed to regard multiple periostitis—the simultaneous production of node-like swellings on various bones—as almost conclusive evidence of specific taint. The cases which I have published, in which such swellings followed quickly after vaccination, have, however, much weakened this impression. To them are added certain others in which evidences of some kind of blood poisoning, with periostitis as a result, occurred without any proof of either exanthem or syphilis. We encounter, too, sometimes with nodes and sometimes without them, certain forms of sore throat most deceptively like syphilis, but in which neither the previous history nor the subsequent progress bear out such diagnosis. It must be admitted that to every one of the cases to which I now refer, some doubt as to the diagnosis was present to the last, and difference of opinion existed amongst those who were consulted. It is, indeed, in this very fact that the main interest of the cases to which I refer consists. Many observers enjoy a high degree of self-confidence in respect to the recognition of specific manifestations, and will pronounce that a given lesion is syphilitic on its appearances, and irrespective of the history and course. I have myself been puzzled sufficiently often to be no longer of the class referred to.

I have to-day to place on record in some detail a case of the kind referred to, in which during a long course of years various opinions had been expressed with great confidence as to whether or not the patient was syphilitic. My own belief

is that he inherited gout and struma, and that under their influence the lesions of syphilis were simulated, but I must speak with some hesitation. In order that my readers may be the better prepared to estimate the items of evidence in this remarkable case, I will briefly recapitulate the facts as regards some others which more or less closely resembled it.

Some years ago a lady of good family, and single, was brought to me by a throat specialist for "a syphilitic throat." Her tonsils and pharynx were covered with white-edged patches of the most suspicious aspect. The surgeon who brought the case would not admit a doubt, and he had already obtained a corroborative opinion from a specialist in syphilis. Yet there was nothing in the history or accompanying symptoms to support the diagnosis. So firmly convinced were my friends as to the nature of the disease, that in spite of my expression of doubt the patient was taken into a home for inunction-treatment, and there salivated. I was assured that when she was finally under the influence of mercury the throat got almost well; but most certainly when she again consulted me some months later it was as bad as ever, and so it remained to my personal knowledge, in spite of all treatment, for several years. I have seen this patient at intervals for at least five years. She still has her sore throat, but nothing has occurred to corroborate the diagnosis of syphilis. Had the throat been specific, I feel sure that it would have got either well or much worse long before this. As to its nature and cause, I am not prepared to give an opinion. It was a most unusual case.

I have recently seen, at the instance of Dr. Fenton, another patient whose mouth reminded me of the preceding. The alveolus, cheek-pouch and part of palate were in a state of chronic inflammation, with ulcers and much formation of white pellicle. The patient was again a young single woman, and there was nothing whatever to support the suggestion of syphilis. It differed from the preceding case in that the conditions were on one side only, whereas in the other they were symmetrical.

In the case of a lad whom I saw at Maidstone in consultation with Dr. Ground, there had been a sore throat with

numerous nodes and an eruption. Yet there was no proof of syphilis, and the patient was not cured by specifics. The stages of development did not in this case fit with the syphilitic hypothesis, and the patient finally died of gangrenous pneumonia. Some potent influence inducing blood changes was evidently at work, but I doubt much whether it was the poison of syphilis. (ARCHIVES IV., page 4.)

The remark last made applies to the Leeds vaccination case, and to another which I recorded at the same time, in which gangrene of the vaccination sores, with periosteal swellings, occurred. In one of these the vaccination was from the calf, and the whole of the collateral evidence opposed the diagnosis of syphilis. (ARCHIVES I., 106.)

A yet more conclusive case in proof that periosteal nodes may attend vaccination fever with gangrenous pocks occurred in the case of an infant who recovered, and in whom no other indications of syphilis ever occurred. (ARCHIVES II., 215.)

In association with these facts I may remark that it is well known that multiple periostitis, with abscesses and exfoliation of bone, may follow smallpox, varicella, and both typhus and typhoid fever.

The patient whose case is sketched in the appended Schedule was brought to me on July 21, 1892, by Dr. B—— of C——. He had just returned from Aix, where he had been treated by inunction without obtaining any advantage. As regards the most painful part of his case, the loss of his eyes, so far from his having gained anything, Dr. B—— assured me that he was in a worse condition than when he went. His left eye was glaucomatous, very hard, and quite blind. The other eye had increased tension of moderate amount, and a widely dilated pupil made very irregular by adhesions. The cornea of this, the better eye, was bright, but it was exceedingly difficult to inspect the fundus owing to the large filmy capacities which occupied the media. There were evidences of neuritis, and some greyish-white patches in the choroid, but for the reasons mentioned, and because I had not much time to give for the inspection, I must not speak on these points with much definiteness.

It seemed not improbable that the long continuance of the

SCHEDULE OF CASE.

Inheritance of gout on both sides—Good health till the age of 16—*A severe sore throat with sore tongue—Many relapses—Syphilis suspected—At the age of* 22 *pustular ophthalmia followed by double optic neuritis, iritis, and destructive ophthalmitis—Renewed diagnosis of syphilis, and long-continued specific treatment—Imperfect results—Loss of both eyes—Death from strumous pneumonia at the age of* 25.

AGE.	DATE.	DETAILS.
16	1884	In December of this year he had a very troublesome sore throat, which was at first supposed to be connected with scarlet fever, but which was not attended by any eruption. There was no proof of contagion of syphilis.
17	1885	The sore throat continued, and sores on the lips and sides of tongue having excited suspicion of syphilis, a consultation was had. The consultant attributed the sore mouth to bad drains, and opposed the idea of syphilis. Many specialists were afterwards consulted, and none prescribed for syphilis.
18	1886	A discharge from the nose occurred. The sores in the mouth continued to recur. Mercury and iodides prescribed.
19	1887	His throat frequently relapsed. He was out of health and liable to a pustular and lichenoid eruption which was called acne.
20	1888	Still liable to relapses of sore mouth.
21	1889	The same liabilities persisted. The diagnosis of syphilis had been long abandoned, and no specific treatment was now used.
22	1890	Liable to swellings on shins (like nodes), and to painful swellings in muscles, which seldom lasted more than a few days. Superficial ulcerations of corneæ.
23	1891	21st of January first seen by his present medical attendant, Dr. B——. The group of symptoms, sore mouth, multiform eruptions, &c., led to a confident diagnosis of syphilis. Double optic neuritis was diagnosed positively as of syphilitic nature. Vigorous specific treatment was begun, and continued for long periods.
24	1892	No improvement obtained, but periodic attacks of kerato-iritis with hypopyon and vitreous opacities. Three ophthalmic specialists confirmed the diagnosis of syphilis. In May sent to Aix, when inunction was employed.
25	1893	Death from strumous pneumonia. In October.

use of atropine was responsible for the increased tension of both eyes. The left eye presented a typical condition of advanced glaucoma, the whole cornea being steamy, and the large pupil presenting a dull, greenish yellow reflex. It was quite impossible in this eye to examine the fundus.

The patient was exceedingly pale and feeble-looking, with chilly extremities. He had on his forehead an indefinite lichenoid eruption, and on his shoulders and back were numerous reddish or livid scars and stains. On many parts of the limbs and body there were groups of spots of lichenoid or acneoid character. About the nature of this eruption it was impossible to say anything definite, more especially as he had during the last year taken much iodide of potassium, which might have produced it. Some of the scars were, I was told, consequent on abscesses after hyperdermic injections. On inspecting the throat I found nowhere any evidences of deep ulceration. The pharynx and sides of palate were pale and patchy, as if superficially scarred, but there was no present ulceration, nor any alterations of contour. On the sides of the tongue were some indistinct filmy grey patches.

There was nothing either in the condition of the skin or the state of the mucous membrane of the mouth or the throat which, if it had not been suggested beforehand, would have led me to suspect specific disease. I had been informed that there had been transitory evidences of periostitis on the tibiæ, and some slight thickening was certainly present on one of them. It was, however, very limited, and the rest of the bone was quite smooth. The lumps which had occurred in muscles and cellular tissue were described as having been very transitory, having usually lasted only a few days. One of these on the side of the left calf was present when the patient was with me. It was an ill-defined, elongated, tender swelling, about as long and as thick as a large thumb, and adherent to the muscle, but possibly not developed in its substance. It had been present only a few days, and was expected to disappear quickly.

The history of what had occurred in the eyes, the repeated relapses of kerato-iritis, the production of vitreous opacities,

made me suspect that we had to do with a case of inherited gout, complicated probably with scrofula. On inquiring as to the family history, I learnt that gout had declared itself strongly on both sides of the patient's family. A paternal uncle who came with him had himself suffered several acute attacks, and he said that another brother was crippled with rheumatic gout, and that their father (the patient's grandfather) had also suffered. On the mother's side there were equally strong facts, and a near relative had died of phthisis. The patient had several brothers and sisters who were in good health.

In reviewing the evidence in this very complicated and obscure case, I arrived at a strong impression that inherited gout was at any rate one very important factor. It, and it alone, would, so far as I know, explain the recurrent and destructive forms of inflammation which had occurred in the eyes. The glaucomatous complication I was disposed to think owing to the long-continued use of atropine, which had been employed with the object of preventing adhesions. In several similar cases in young persons I have observed a remarkable tendency to increase of tension from atropine, and have been obliged to disuse it. Respecting the eruption which had developed on the skin, it is not necessary to be very precise. It had been regarded in the first instance, and probably with reason, as acne, and it had been subsequently complicated by the use of iodides. The swellings in the cellular tissue, or muscles, and those on the periosteum of the tibiæ, had been of much more transitory character than is usual with specific gummata. We have, lastly, the state of the mouth. This it is perhaps difficult to connect in any way with gout, but at the same time it must be asserted that nothing really characteristic of specific disease had shown itself at any stage. The theory of syphilis was that a sore on the lip had been contracted accidentally (smoking, &c.) in 1885, and that the disease had proved so persistent in the mouth because that was the part first affected. Against this, however, was the fact that during the first and long persisting sore throat there was no eruption whatever; that although at different times several surgeons had diagnosed the mouth as

syphilitic, others (the majority) had held a different opinion; and lastly, that it is an occurrence almost unknown in the history of syphilitic throats for disease to persist and to relapse for five years without assuming a tertiary character, and causing destructive ulceration. Nor is the entire failure of specific treatment as a cure without its significance. During a year and half prior to my consultation mercury and iodides had been used with great vigour. Mercury had been given by the mouth, by inunction, and by hypodermic injection. When the optic neuritis appeared three ophthalmic authorities pronounced definitely for syphilis, and the patient was made to keep his room and use inunction most liberally. Unless, perhaps, we consider that the throat healed under the influence of these measures nothing was gained. The eyes became worse, and respecting the throat and mouth it is to be remembered that cures and relapses had been occurring under various treatment for upwards of four years.

Against the diagnosis of syphilis we had—

The absence of any known chancre.

The absence of any secondary eruption.

The very long persistence of the sore throat.

The judgment given by several surgeons at different stages that the sore throat was not a specific one.

The course taken by the ophthalmitis.

The inefficiency of specifics.

For the diagnosis of syphilis we had—

The judgment of several surgeons that the ulcers in the mouth and throat presented characteristic features.

The judgment of three ophthalmic surgeons that the optic neuritis was characteristically specific.

The occurrence of periostitis.

The cure of the sore throat, &c., apparently by specifics.

For the diagnosis of inherited gout we had—

The strong family history.

The relapsing character of all the phenomena.

The destructive nature of the ophthalmitis.

The close conformity of the disease in the eyes with what is well known in connection with gout in young persons.

(*To be continued.*)

LENTIGO-MELANOSIS.

A FURTHER REPORT.

At page 319 of Archives, Vol. III., will be found the particulars of a case in which, in a lady of sixty, senile freckles on the lower eyelid had advanced to condition of melanotic staining. I now revert to the case in order to add some additional facts of considerable importance. During the two years which have elapsed the staining has very slowly advanced, and there has also occurred (as in some other cases) a malignant growth on the edge of the lid. This is exactly what happened in the case of Sir A. D., which I published at the same time (p. 320). The two cases are the exact repetitions of each other. In both the melanotic staining had been slowly aggressive for many years before any tendency to malignant new growth showed itself, and in both the latter, when it did occur, developed rather rapidly and was marked by a non-pigmented structure.

I am now able to produce a portrait (see Plate) which will enable the reader far better than any description to realise what is meant. The middle figure in Plate CVI. shows the eyelids of the patient whose case I now supplement. In the lower left-hand figure the same eye is shown with the lid drawn down so as to exhibit the staining of the conjunctiva and margin of cornea. This condition had been attained by slow spreading and coalescence of what at first looked like dark freckles during six years, or possibly much longer. The portrait was taken in 1892. In June of 1893 the patient came to me with an ulcerated growth involving the middle of the edge of the lid. It was as big as the tip of one's little finger, and had developed in the course of about two months.

There was no gland disease. I had no hesitation in advising its immediate excision. Having first asked my patient to show her curious lesion to Sir James Paget, I freely removed a V-shaped portion of the lid. The wound healed at once, and as yet there has been no recurrence.

The operation afforded an opportunity for microscopic examination, and I now append a report by my eldest son of the results obtained. No. 1 refers to the growth, and 2 to the melanoid skin adjacent to it.

Report on Case of Melanotic Staining of Eyelid with a Sarcomatous growth (*by Jonathan Hutchinson, Junr., F.R.C.S.*).

Sections were cut at right angles to the surface so as to traverse both skin and mucous membrane, and on microscopic examination the following points were made out.

1. In the centre of the lid, *i.e.*, at equal distances from the skin and conjunctiva, a mass of deeply pigmented cells was found, the pigment occurring as fine brown granules, or sometimes as black masses filling the cells. The latter were of very varying size and shape, frequently spindle-like, but as a rule rounded or oval. Some were so large as to suggest an epithelial nature, and here and there groups of them were surrounded by a connective tissue capsule, so that the appearance was not unlike some form of cancer. Nevertheless, on the whole, the nature of the infiltration seemed to be clearly sarcomatous. This was most evident, perhaps, towards the periphery, where the fibres of the orbicularis muscle were invaded. At the centre all trace of muscle had disappeared. The Meibomian and other glands on the conjunctival surface of the growth were little affected, in fact appeared to be quite normal, and the same may be said of the cutaneous sweat and sebaceous glands. The process of invasion of individual striped muscle fibre by the various cells could be clearly traced, columns of the latter growing up inside the sarcolemma so as to completely fill it. Only a small portion of the central mass was pigmented, the densest colour being found towards its centre, as is generally the case with melanotic sarcoma.

2. Pigment was found in the sections in two other situations than the central new growth ; first as a thin layer of pyriform or oval cells just below the conjunctival epithelium, but quite distinct from the latter; and secondly in a similar situation on the cutaneous surface. The epithelium in both places was practically free from pigment.

Comments on the Group of Cases.

In the uppermost of the figures in Plate CVI. are shown the eyelids from another patient affected by the same malady, but with some minor differences. In nearly all the cases which I have seen (counting, if I may reckon some in early stages, about ten) the pigmentation has much preponderated on the right side. This is the reverse of the law in xanthelasma of the eyelids. In the portrait now given, however, the left eyelids show the largest and blackest freckles. The malignant growth also, instead of being on the edge of the lid and in the middle of the stained patch, is on the skin of the lid at some little distance both from its edge and from the black patches. It is itself wholly free from pigment. I have seen another case which exactly repeated these conditions.

Apart from the importance of their clinical recognition, much interest appears to me to attach to this group of cases as illustrating the laws under which physiological processes slide into malignancy. We have first freckles such as are seen on the eyelids of many elderly persons, these become very black and enlarge. Next the freckles coalesce, and we have a patch which is infective at its edges, and which may extend to the adjacent mucous membrane and even to the cornea of the eye. Still there is nothing to be called new growth, the process being simply one of pigmentary staining without appreciable thickening. Lastly, however, another stage is assumed, and a growth takes place which is for the most part unpigmented, and which in its tendency to break down and ulcerate reveals its malignant nature. In some cases this final growth is of epitheliomatous structure, and in others sarcomatous.

This form of disease is not limited to the eyelids, although

its most typical examples are seen on them. I have already described examples of it on the lips and on the prepuce. Since I last wrote on the subject, I have also found in Bruns' Atlas a figure which appears to show this condition on the lower lip. The melanoid staining is extensive, and the new growth of considerable size and thickness.

PLATE CVI.

SENILE FRECKLES.—MELANOTIC STAINING.—EPITHELIAL CANCER.

The uppermost figure in this Plate represents the condition of the eyelids in Mrs. P. L., whose case was given in 'Archives,' vol. iii., p. 321. She was the subject of senile freckles, which on the left side had advanced to a condition of melanotic staining, and were accompanied by a small, unpigmented epithelial growth. This latter growth is seen on the lower eyelid under its outer half. The pigment patches, which are near it, were gradually extending. It will be seen that on the eyelid of the opposite side there are some slightly-marked patches of pigment staining. Some treatment by scraping had been practised for the cure of the epithelial growth before I saw the patient. I had some doubt as to whether the little nodules shown in the portrait were not of the nature of keloid; but as the patient passed from under my care, I had no opportunity of making a microscopic examination.

The central figure shows the state of the eyelids in another lady of about the same age as in the preceding case (sixty-two years). It will be seen that the lower eyelid is very extensively pigmented. The stained part was mostly but little, if at all, thickened. The pigmentation was definitely aggressive, and has extended very considerably during the three years that the patient has been under my observation. There is little or nothing on the opposite eyelids which can be counted as senile freckles; but it will be seen that there is a little nævus very near to the edge of the lid. A similar and larger nævus is seen just over the inner canthus on the right side.

The left-hand lowest figure represents the eye of the same patient as the preceding, at a somewhat later stage. The lower eyelid has been drawn down, in order to show that the conjunctiva and even the cornea itself are pigment stained. At the present date,

two years after this sketch, the conjunctiva has become of a very deep brown, and in the cornea a narrow margin of sepia tint, affecting the arcus senilis, has extended round almost the entire circle. Only a very small portion of the corneal rim, in the middle line under the upper lid, is now free from staining. After watching this case for three years, much in the condition shown in the sketch, I have recently had to excise a portion of the lower lid on account of an epitheliomatous growth close to the edge, which, although still of small size, was developing rapidly. It was not pigmented. I have not attempted to remove the pigmented parts, as it will be seen that not only the eye itself, but the upper lid also is involved.

EARLY STAGE OF EPITHELIOMA OF THE TONGUE.

The right-hand lowest figure shows the portion of the tongue, which I excised in the case of the late Mr. K. The little ulcer here shown had formed in connection with a sharp tooth, when Mr. K. was sent to me by his dentist. The characters of the ulcer are well shown. It was small, clean and quite superficial; but it had a rolled edge, and a slightly hardened base. It had been present only a few weeks. The sketch, which was made after the operation, will prove that I excised it freely. No return of the disease ever took place in the tongue itself; but the patient died two years later from secondary disease of the glands of the neck.

This sketch may, I hope, prove useful in assisting towards the diagnosis of cancer of the tongue at an earlier stage than is usual. Perhaps cancer of the tongue was never in any case excised, whilst apparently so insignificant or under conditions apparently so hopeful as to permanency of recovery. Yet, as has been shown, the lymphatics were already infected.

West, Newman chromo.

DISEASES OF THE NERVOUS SYSTEM.

No. LXIV. — *Slow and imperfect mental development—Defective formation of Nails and Hair—History of a very prolonged birth with nearly fatal results to the infant.*

There are some interesting points in the following case:— Mrs. C——'s child was sent to me with the double diagnosis of cretinism and rickets. Probably it had but little relation to either. The child, a girl nine years old, had an idiotic expression and a large head and face. Her cheeks were very full; the lower lip projected and the tongue was constantly partially protruded. The nose was flat. Her expression was that of placid stupidity; but her mother assured me that she was "a lot sharper than you would think to look at her," and that, when quiet at home, she could say almost anything. She never made the least attempt at speech in my presence; but she was quite docile during a long opthalmoscopic examination. It was very difficult to get her to fix her eyes on anything. She could but just manage to walk in a weak, waggling fashion. Her scalp hair was very thin, weak, and scanty, and I was told that her nails had formerly been very small and weak. Of late they had much improved. Her hearing and sight appeared to be perfect. I was told she was very cleanly in her habits, and that though formerly she used to cry a great deal, she now but seldom did so. The circumference of her head was 20 in., the measurement from ear to ear being 12½. Her mother had other healthy children. The history given was that her birth was by a breech presentation and a very prolonged difficult labour; that she lay for several days between dead and alive, but that finally she

appeared to thrive pretty well during the first year of infancy. She was considered to be a restless baby; but it was not till the end of the first year that the mother took any alarm as to her mental condition. She was very slow in learning both to walk and to speak. At the age of two she could only say one or two words; she did not walk till she was six.

It appeared to be a case in which both the mental powers and the ability to use the limbs were gradually improving.

It does not seem unreasonable to suspect that in this case general defect in the child's nervous system was induced by the influence of the very prolonged labour upon the circulation in the brain. It is clear that this all but caused death.

No. LXV.—*Fatal Tetanus after plugging of the nostrils for Epistaxis.*

The following are the particulars of a case in which a man died from tetanus in consequence of plugging of the nostrils. I saw Mr. B——, a gentleman aged 60, in October, 1865, in consultation with Dr. Evans. The reason for our meeting was that symptoms of tetanus had set in, and that it had been found impracticable to remove some plugs from his nostrils, which had been put in ten days before. The history given was that he had suffered from such profuse epistaxis that he was quite blanched. Dr. Evans, having tried various other remedies, finally plugged both nostrils with sponge. Silk ligatures were, as usual, attached to the sponge; but the plugs had become so firmly fixed that no ordinary force could dislodge them. The plugging was done on September 30th, and I met Dr. Evans and the late Dr. Habershon in consultation on October 10th. The patient then had definite trismus, which had been present forty-eight hours. He had spasms, and had bitten his tongue more than once. We administered chloroform, and I then with forceps took out the plugs, which were very firmly fixed. No bleeding occurred. The trismus continued, and although there was no great increase in the tetanic spasms, the patient sank during the following night. I was told that he had enjoyed

good health before the attack of epistaxis, which was the first that he had ever had.

This case is of interest, not only as an example of fatal tetanus from an unusual cause, but as exemplifying the occasional dangers and inconveniences which may result from plugging the nostrils. For many years I have never in any single instance adopted this practice; and the case narrated was one, with others, which gave me a great prejudice against it. Without, however, laying undue stress on the fact that the plugs, if large and efficient, are not unfrequently very difficult to remove, I may allege as a much stronger reason against the practice that it is wholly unnecessary. Since I have adopted the practice of placing patients with severe epistaxis in the sitting position and with the feet in a deep foot-pan of very hot water, I have never once failed in arresting the bleeding. I have, in one or two cases, continued the pediluvium for several hours, and never with any inconvenience.

No. LXVI.—*Paralysis Agitans affecting the Right Limbs only.*

Mr. G——, a gentlemen whom I treated twenty-five years ago for chronic strumous disease of one elbow joint, and who recovered (under cayenne pepper) with complete ankylosis of the ulna and humerus, has recently consulted me for new symptoms. He is now (June 29, 1891) the subject of a curious form of paralysis agitans, which affects the right limbs only. Both the upper and the lower limb are usually involved in shaking at the same time; thus if he attempts to use his right hand, both hand and foot begin to shake. His right foot is always shaking when he is at meals or attempting to write. There is nothing amiss with the left limbs. He thinks that the right limbs are always colder than the others, and, as far as he observed, the shaking began only six months ago. Any slight excitement causes these limbs to shake. Mr. G—— is a well preserved and intelligent man, aged 57.

In reference to his elbow joint, I may note that the limb

has been very useful to him for all purposes, and that, although the ulna and humerus appear to be firmly fixed, he can still rotate the radius.

No. LXVII.—*Herpes Frontalis severe but almost painless.*

The importance of correct diagnosis is sometimes brought before one's attention in curious ways. A gentleman consulted me because his hairdresser had threatened him with an action for slander causing loss of business. The facts were as follows :—

My patient, a man of about 50, and almost bald, went to his hairdresser to have what remained of his scalp-hair cut. A hair-brush was used which gave pain, and almost immediately after his return home he noticed some red points on his scalp, as if he had been scratched. The next day an eruption came out with much swelling and redness "like erysipelas." He took for granted that he had been poisoned by the brush. The hairdresser, on being informed of what had occurred, at first promised to bear all expenses for his treatment; but subsequently, having been better advised, and discovering that his client had made no secret of the misfortune, and that he was losing his custom in consequence, he not only declined to do anything of the kind, but, as already stated, threatened proceedings for slander. Under these circumstances the case was brought under my notice, in order that I might give a certificate that the eruption was undoubtedly due to the hair-brush. I found, however, that it was a splendid example of herpes frontalis. The crusts had not yet fallen, and the right half of his face and scalp, from his eyebrow to his parietal eminence, was covered with thick crusts which were strictly limited to that side. I was obliged to assure my patient that he was wholly mistaken in his suspicion, and advise him to make his peace with his hairdresser as promptly as he could. He still urged that the eruption had followed immediately after the use of the brush, and that he had seen some red points as early as the evening of the same day. This, I explained to

him, was the most conclusive point of all that the brush had nothing to do with it, since herpes always takes a few days for its development.

I may just add that this case was a remarkable instance of severe herpes in a man past middle age with little or no pain. The man denied that any pain had preceded the eruption, and although for a few days, at the height of the inflammation, the scalp had been very sore, it had quite passed off when I saw him at the end of eighteen days.

No. LXVIII.—*Case of Shingles attended by general Eruption.*

As is well known, herpetic inflammations have no tendency to affect the adjacent skin, and never spread. A very extraordinary seeming exception to this came under my notice in the person of a gentleman from —— named S——, aged 53. Three weeks before I saw him (May 20, 1893), whilst in excellent health, he had begun to experience a pricking in his back and arm, for which he consulted a medical man, who prescribed arsenic. From his account I should think the herpes was just coming out at the time, and should not incline to attribute the latter to the arsenic. When I was consulted there were large groups of scars, extending from the middle of his back across the lower angle of the scapula and round the front of the chest. These were characteristically those of herpes zoster, but were unusually florid and irritable looking. The remarkable point of the case was, however, that all over the neighbouring parts of the chest, shoulders, and arm, there was a plentiful crop of a pustular eruption almost like that caused by antimony. I thought that some irritant must have been applied for the cure of the herpes; but he assured me that he had used nothing stronger than vaseline. There were a few scattered pustules on the upper part of the arm on the opposite side. The arsenic, for which he brought me the prescription, had been prescribed, on May 9th, in five-minim doses of Fowler's solution. This was eleven days before I saw the patient. It seems scarcely probable that arsenic could have produced the

scattered pustular rash just described, but it is not unlikely that it had been a means of delaying the healing of the herpes, seeing that its administration had been commenced at a time when the latter was fully out. I do not think that I have ever witnessed a similar occurrence.

No. LXIX.—*Recurring Herpes on the same spot on one thigh—Possibly Gouty.*

A gentleman named H——, aged 40, whom I had treated twenty years ago for syphilis, and who had remained apparently quite well, became liable to a patch of herpes on the outer part of his right thigh, which recurred almost exactly on the same spot in the spring of every year on seven occasions. Now and then it would occur in the autumn also. He was never especially ill, but he considered the spring as the worst time of year for him. In the spring of 1893 his herpes did not occur, but he had a troublesome attack of rheumatic sclerotitis, which during several weeks changed from one eye to the other. He was of gouty family, and of liberal habits of life.

No. LXX.—*Occipital pain after sexual intercourse —Epileptiform insensibility.*

A man who consulted me (July 19, 1875) on account of exostosis of the upper jaw, told me, in discussion as to his general health, that, for several years before his wife died, sexual intercourse had such an injurious influence upon him, that he had entirely avoided it. Immediately on the completion of the act, he experienced "a dreadful sensation in the back of the head" as if he would die, and became for a few minutes unconscious. He always managed to conceal it from his wife, but the attacks alarmed him so much that he determined to entirely abstain. Instead of telling his wife, he made business his excuse for living in another town, and never afterwards saw her except in the presence of one of their daughters. He took the latter precaution because, his appetite having by no means left him, he was

afraid of being tempted to break his rule. Other patients have told me of similar symptoms though with less emphasis.

No. LXXI.—*Hysterical Aphonia—Sudden and complete recovery.*

The following facts are of much interest in reference to temporary suspension of nerve function in connection with the hysterical temperament. In April, 1875, I was attending Capt. C——, who was nearly blind, and used to hear frequently from his wife her regret that, owing to her loss of voice, she could not, as was her custom, read to him. For a month or six weeks she never spoke louder than a whisper. She had had several similar attacks of nervous aphonia. Suddenly one day I found her speaking with a loud, clear voice, and in great delight that her voice had returned. She said she could read for an hour together quite easily. On inquiry as to what treatment had been successful, she told me that she did not attribute her improvement in the least to the remedies employed. One morning, while dressing in a hurry, she had broken her stay lace, and, in the excitement of the moment, she exclaimed, "Oh bother!" in a clear voice. From that time she continued able to speak quite well. I cannot think that in this case there was any organic disease or any attempt at malingering. Possibly, in the beginning, some slight catarrhal affection of the larynx might have been present; and there remained afterwards an inability on the part of the will to again arouse the muscles, which had partially failed in function.

There were other facts of great interest in Mrs. C——'s life history. I asked her if she had ever been hysterical, and she said, "Oh, yes, before my marriage often so." After her marriage also on one occasion, when very anxious on account of her husband's illness, she one morning got out of bed to get him some medicine, and suddenly lost the use of her limbs on one side. The hand and leg became numb, and her face, she says, was distorted. She well remembers that she could not feel, as she says, in the least, in either the upper or lower extremity, whilst her attendants were rubbing

them. Great alarm was occasioned by this attack, but in a few days she entirely recovered. She has always considered herself a very nervous person, but has had no serious disease. She is a stout, comfortable-looking person, aged about 50, the mother of several children.

THERAPEUTICS.

No. XXXIX.—*Report of results from Excision of Diffuse Lipomata—Use of Sulphide of Calcium.*

In Archives, Vol. III., p. 134, I have recorded a case in which I had treated a case of diffuse lipomata of enormous size by operation. Very large masses of fat had been excised from the back and sides of the neck. I have recently seen this again, and can now report the result after three years' interval. It has been excellent. Formerly the patient was unable, on account of the grotesque disfigurement, to go into society; now there is nothing to be seen which would excite notice. He looks somewhat full about the claps, but that is all. The back of his neck is of normal contour. There has not been the slightest reproduction of fat where the masses were excised. I did not at the operation remove nearly the whole of the growth. Those under the lower jaw and in front of the neck were left untouched, as if I had meddled with them I should have had to skin the whole neck. During the three years there has been decided and steady diminution of these also. Soon after the parts were healed from the operation, the neck measured in girth twenty-three inches. It now measures only seventeen. At three stages he has had to reduce the size of his collars. Three different influences may have contributed to this result. He has recently in connection with liver disease, possibly malignant, lost flesh and fat generally. I do not think that this accounts for much, because the diminution was observed to be in progress two years ago. The chief influence has been, I believe, the steady use of sulphide of calcium. He has taken one-grain pills of this salt twice a day, almost continuously. Messrs.

Richardson, of Leicester, who make these pills as a specialty, inform me that they have supplied seven gross in little more than two years. The patient himself is firmly convinced that the pills have had great influence in reducing the size of his neck, and it is to be observed that although I enjoined abstinence from beer and extreme moderation in stimulants, he has not been strict in this matter. He admits having had one glass of beer a day. I inquired whether the pills thus continued for so long a time had shown any influence on his general health. He said: "None but good." He had been in much better health than formerly. Irritation at the anus was, he thought, the only inconvenience which they ever produced. He has now cirrhosis of the liver, and some symptoms which suggest malignant disease of the stomach.

No. XL.—*Use of Opium in Incurable Disease.*

There are circumstances under which the opium habit is not to be shunned. In those who are the subjects of incurable disease of a painful character, and who are not likely to live more than a few months, the free use of opium is permissible, and adds greatly to the comfort of life. Thus, in cancer cases which are beyond hope of relief, I never scruple to recommend opium in any form that agrees, and in any dose that is required. It is an invaluable remedy. It is not in all cases that increase of doses is necessary, but should such be the case we need not hesitate. If life is not to be extended over more than three months, the habit will not be attended by the ill-consequences which so often outweigh the benefits in protracted cases. It is cruel to forbid nepenthe or morphia under such circumstances.

No. XLI.—*Arsenic as a Cause of Herpes Zoster.*

I observe that Dr. Railton, of Manchester, has been treating chorea in children with very large doses of arsenic. He gave fifteen drops every eight hours. Several of his patients suffered from the symptoms of peripheral neuritis, to which others as well as myself have repeatedly drawn attention as

occasional consequences from this drug. I am personally interested more especially in his statement that three had shingles. As the total number so treated was only nine, we have a very strong confirmation of the opinion that arsenic can cause herpes.*

No. XLII.—*The Relief of Tabetic Pains.*

A physician, himself the patient, told me that for the relief of the pains of tabes he had found phenacetin the best remedy. He was accustomed to take it in fifteen-grain doses, putting the powder on his tongue. This dose he would take every four or six hours when the pains were severe. He had formerly tried antipyrin with great relief, but with, he thought, the result of inducing some debility. It made him perspire, and also made his lips blue from retarded venous circulation. I have myself usually been in the habit of prescribing antipyrin for this object, and have not met with much if any inconvenience from it. Morphia is, of course, the most effectual of all; but its effects are so pleasant, that it almost always induces habitual use and increase of dose. It is to be most emphatically avoided by all tabetics.

No. XLIII.—*A Patient's choice of Hypnotics.*

A non-medical friend of my own was an expert in hypnotics, having suffered much from insomnia, and having had advice from many medical friends. He finally came to anchor on opium and chloral, not taken together, but in separate doses with a two hours' interval. His dose was one to two grains of opium before going to bed, and a drachm of the syrup of chloral an hour after getting into bed. He had previously found that chloral alone did not agree, but with the combination referred to he had not failed during the last two years of his life to procure a fair night with refreshing sleep and no inconvenience on waking. He had not found it needful to make any increase of the doses, and congratulated

* See a paper by Dr. Neilson in a recent volume of Dermatological Papers published by the New Sydenham Society.

himself on having found out for himself that which suited better than anything which his physicians had contrived for him.

No. XLIV.—*On the Influence of Arsenic in preventing Catarrh.*

Some facts which have during the last few years come under notice favour the belief that the liability to catarrhal attacks of all kinds may be controlled by arsenic. I have already many times published the opinion that the tendency to recurring attacks of herpes may be prevented by it. One of the most striking instances of its efficiency as regards common nasal catarrh which I have had is the following.

A lady, aged 50, consulted me in April last on account of filmy patches on her tongue, for which I ordered arsenic. The remedy agreed well, and as the tongue did not much improve, she, under the advice of her family surgeon, increased the dose until she was taking seven minims three times a day. She has recently told me that it had the most remarkable influence on her health. Her appetite and vigour have much improved, but she adds, "the most curious thing is that I now never take cold. For thirty years I had been very liable to catch cold. In winter I was rarely long without one, and I could never bear the slightest exposure to damp or chill. This winter I have never had a cold, nor have I had anything of the troublesome cough from which I used to suffer."

It may possibly be the fact that arsenic tends to prevent undue reflex susceptibility of all kinds. If so, it may prove a valuable test as to the true nature of the maladies for which it is a specific. I have already suggested this in what I have written at page 1 of Volume V.

No. XLV.—*Opium* v. *Dover's Powder.*

It may seem but a little matter, yet it is, I think, worth mentioning, that I have of late found powdered opium much preferable to Dover's powder as a corrigent of the purgative effect of mercury. My prescription for many years was a pill

containing one grain each of grey powder and Dover's taken four or five times a day. Usually it was unattended by any inconvenience from diarrhœa, but not invariably. Many of my friends who prescribed it, and who were possibly less emphatic than I am in reference to diet, used to complain that the pill purged their patients and had to be left off. Of late I have ordered a tenth, eighth, or sixth of grain of powdered opium instead of the compound ipecacuanha powder, and with, I think, much more certain results. It is a very rare event indeed to have any trouble from diarrhœa. There never was any good reason for prescribing the ipecacuanha excepting a vague impression that it qualified the opium. As is well known, under certain conditions it is itself laxative.

No. XLVI.—*On the Habitual Use of Opium.*

It will be a strange result of the Opium Commission if it should lead to a larger and more general dietetic use of the drug. It is, however, by no means impossible. Evidence seems to be forthcoming from many authorities as to the apparent benefits obtained from the habitual use of small quantities. If professional attention be attracted to the subject, it may lead to a more general recognition of its advantages to a very large class of patients. I am in the habit of using it rather freely, in minute doses, long continued, in a variety of ailments in elderly persons. It seems to favour the peripheral circulation and thus to help nutrition in distant parts, much as a generous wine (port or madeira) may do. Mr. Skey and others have written warmly in its praise in cases of chronic ulcers on the legs. Mr. George Pollock published an article of much interest as to its power in certain forms of disease, including sore mouths of a peculiar kind. I have myself recorded some very remarkable cases of cure in which it appeared to act as a specific when everything else had failed. It is quite possible that the number of old persons whose lives would be rendered much more comfortable by the habitual use of small doses of opium is very large indeed. We must, of course, never forget that it stands in the same category with alcohol as one of those drugs

which in some persons agrees too well and creates an appetite for more. Thinking and writing as medical men we must, however, deal with the facts as they are, and place our knowledge fully and honestly at the disposal of the public. No good can come of concealment of the truth. Let us devise such precautions as are needful with a full and clear knowledge of our real position.

No. XLVII.—*Acute poisoning by Iodides—Œdema of pharynx the first symptom.*

I ordered for a lady, who much needed it, a mixture containing, together with a drachm of the solution of mercury, four grains of the iodide of potassium and two of the iodide of sodium. These ingredients, together with a drachm of tincture of bark and two drops of Battley, made up the dose which she was to take three times a day. She took but two doses, when she was seized by a sense of construction and swelling in the throat, followed by general soreness of mouth and lips, and in the course of a few hours by burning of the whole skin and an eruption of large erythematous wheals over the limbs and body. She passed a sleepless night in extreme discomfort, and the next morning was so ill that her husband insisted that I should come to see her. She had been liable to nettlerash before. The eruption took the form of patches of erythema as large as the outspread hand, which occurred on the neck, face, chest, and thighs. They differed from nettlerash in not being pale in the centre, and also in being persistent and larger and more raised than is usual in that disease. It was quite obvious that the whole was due to the iodides, and within a few days all the symptoms had disappeared. I examined the urine, but there was no proof of renal incompetency.

The symptom of swelling in the throat as the earliest indication of iodide poisoning has been noticed in other cases. I remember that of a man brought into the London Hospital in whom tracheotomy was only just in time to save his life. Nor is the promptness with which the acute symptoms showed themselves any exception to rule. In those who are liable

to iodide-poisoning it is a matter of mere idiosyncrasy, and neither dose nor time have anything to do with it. The symptoms set in immediately after the drug is given, and may be very severe after a very small dose. I have thought the case worthy of record, although not exceptional, because it affords an important clinical lesson.

No. XLVIII.—*Cirrhosis of the liver in a boy—Recovery.*

A young man, aged 28, brought his father to me. It was incidentally mentioned that nineteen years ago I had treated the younger man himself, then a boy of nine. I was told that I had cured him of a "drunkard's liver." This diagnosis I found was not mine, but that of a distinguished physician who had seen the case before I did, and who told the boy's father that he had seen only one other similar case (*i.e.*, cirrhosis of liver) in a child. There had not been any previous abuse of alcohol. I found that the man was still taking the prescription which I had given him so long ago, and that he believed it to be "the only thing which would touch his liver." He was now in fair health, but still liable to dyspepsia. As a boy it had been expected that he would die, and he was for long an invalid. I was of course curious to know what the prescription contained which had worked such wonders. It was subsequently sent to me, and I found that it was not mercury, but taraxacum and nux vomica together.

DISEASES OF THE SKIN.

No. LXX.—*A single Bulla on the Cheek repeatedly recurrent.*

Mrs. McT—— was sent to me by Dr. Hamerton, who had been much interested in her case. She had a single bulla of pemphigus, as large as a sixpence, on the middle of her left cheek. It was very abruptly margined, and a quarter of an inch in height. It contained a yellowish serum, and some pus corpuscles had gravitated to the bottom, just as in hypopyon. Near to this bulla, extending upwards towards the angle of the eye, there were some suggestions of abortive vesicles. Her statement was, however, that she had on former occasions never had more than a single bulla. Ever since November last—*i.e.*, during eight months—she had been liable once a fortnight to the formation of a bulla in exactly the position, and of the same character, as the present one. She thought that each bulla had occupied about eight days in its stages, and that she was usually about eight days free. She did not appear to have ever suffered from herpes. Her statement was that on the first occasion there was only a pimple, which did not actually blister; and it was not until this had recurred several times that she became liable to have a bulla form.

A portrait of this patient has been preserved in the collection of the College of Surgeons.

No. LXXI.—*Chilblains in Senility with Dry Eczema.*

The acrodermatitis of senility was well illustrated in the case of Miss F——, aged 64. She had, when she consulted me in April, 1893, been liable for three years to dry eczema of

her palms and fingers. At first it used to come only in the winter, and at the very tips of the fingers, but of late it had extended upwards to the whole hand, and during the last summer it had persisted more or less. She had had a great deal of treatment, and had tried all sorts of superfatted soaps, &c., without any relief. Her condition, although much less severe, was like that of Mrs. ——, whose hands were cured by opium, but who had several relapses, and finally a very severe attack of eczema-erysipelas. See ARCHIVES, Vol. II. p. 192, Plate 22. Miss F—— did not complain of any irritability of her skin, and was not liable to Raynaud's phenomena. She had, during the last ten years, suffered from chilblains in cold weather.

No. LXXII.—*Acrodermatitis.*

Another very good example of acrodermatitis of the eczematous type occurred in the case of a Miss E——, whom I saw on June 19, 1893. It was what is often called "dry eczema of the fingers," and consisted solely of dry, very rough, peeling patches. There was scarcely any congestion, and no trace of exudation of any kind. Her palmar surfaces were so rough that they scratched those who shook hands with her. Miss E—— belonged to a family in which there was undoubted gout. She had herself been a beer drinker most of her life. She had, however, never suffered from actual gout. The soles of her feet were much complained of as being hot and dry, but they showed no eruption. Her nails had not been in any way affected. She said that the first patches had appeared on the very tips of her fingers, which became dry and hot. This was more than three years ago, and the condition had been steadily advancing ever since, without any benefit from a great variety of remedies, which had been very judiciously prescribed. She had never had any eczema elsewhere. Her age was about fifty-five.

We must divide our cases of acrodermatitis into two groups —one in which the nails are definitely affected, and one in which they wholly escape. My impression is that, when there are dry, peeling patches on the tips of the fingers and on their palmar aspects, the nails usually escape. When the

dermatitis is more diffuse and affects the backs of the fingers as well as the fronts, then the nails usually suffer.

No. LXXIII.—*Syphilitic Sycosis-Lupus of the upper lip simulating Rhino-Scleroma.*

Mr. P——, aged 36, from Dr. C—— of P——, afforded a good type example of syphilitic sycosis-lupus, located on upper lip, and caused by discharge from the nostrils.

He was sent to me as an example of lupus vulgaris, and scraping had been advised. The ragged character of the patch and the absence of "apple jelly" made me feel certain that there was syphilis in the case. The patch involved the part of upper lip immediately beneath the nostrils, and hairs of the moustache had been almost wholly destroyed. There was much lumpy thickening covered by dry adherent crusts, which could not be removed without causing bleeding. It might be counted as a form of syphilitic rhino-scleroma. It had been slowly spreading for eighteen months.

Mr. P—— admitted gonorrhœa eight years ago, and about the same time had warts under the prepuce. He was never treated for syphilis, so far as he knows. He had had, two or three years ago, an ulcer on his scalp, much like that now present on his lip, which has healed and left a scar. It lasted twelve months, and he was under many doctors.

I have ventured in the above heading to give a partnership name to a partnership malady. The disease was doubtless, in a sense, syphilitic—that is, the patient's state of nutrition and his proclivities had been modified by a former attack of syphilis. Probably, however, he would never have had the sore on his lip had it not been for the irritation caused by catarrhal defluxion from his nose. We encounter many troublesome cases of chronic sycosis of the upper lip which originate and are perpetuated by this simple cause. A few of these may, if utterly neglected as to treatment, and especially if occurring to patients who inherit tendencies to both struma and cancer, run on into hypertrophic and infective conditions. It is, so far as I understand the matter, to growths acknowledging these varied elements of causation that the name Rhino-scleroma is given.

No. LXXIV.—*Xanthelasma Palpebrarum—The same in several of the patient's children.*

An old lady named C——, whom I saw with Mr. Benjamin Duke, was an interesting example of the family and hereditary prevalence of xanthelasma. She was sixty-four years of age, and had large patches of xanthelasma of characteristic colour, but extremely thin in substance, on both sides. They were quite symmetrical, and on both sides there were little patches at the outer canthus, as well as large ones around the inner. The history was that she had had them slowly increasing for five-and-twenty or thirty years. She had been liable to sick headaches, and on two occasions she had been all but jaundiced. She was not aware that any of her predecessors had presented the same peculiarity, but three or four of her children had them.

No. LXXV.—*Leucoderma in association with Alopecia—Alopecia following Ringworm.*

Mr. C. D——, aged 28, who had come from Australia (where he was born), consulted me on June 30, 1893. At the age of fourteen he had ringworm, and since then had suffered from alopecia, which had become universal. For the last fourteen years he had worn a wig. He was also the subject of leucoderma, occurring in spots and streaks on his hands and wrists and on his scrotum. Almost the whole of the latter was quite blanched, with abruptly edged patches at the root of the penis. The spots on the hands were small and indefinite. The lower eyelids were bleached, at their outer canthi, in patches with abrupt edges.

Mr. D—— informed me that he believed there was much ringworm in Australia. Probably there was no connection whatever between the alopecia and the leucoderma.

No. LXXVI.—*Peculiar conditions of Congestion of the Nail-bed.*

In many persons there may be noticed an ill-defined border just below the free edge of the nail which is of a deeper tint

than the rest of the nail-bed. Perhaps most persons can by pressure of the finger ends on some hard body make this line conspicuous. In some conditions of feeble health the border to which I refer becomes much exaggerated, and of a livid purple tint. I have just noticed it (May 17, 1893) in the fingers of a lady, aged thirty-seven, who recovered six months ago from a severe miscarriage, and who suffers from nervousness amounting almost to decided depression. Although not apparently out of health in other respects, her circulation is feeble; and on her hands, and especially on her fingers, there are many little scars and purplish spots. She complained much of headaches, chiefly in the back of the head, which made her "giddy and stupid." There was a perforation of the septum nasi at the usual place just within the nostrils, which would have admitted the end of the little finger. Its edges were soundly healed; and, being associated with chilblain-scars on her fingers, I am inclined to think that it was of lupoid character, and not syphilitic. There was no reason to suspect syphilis. As regards the purplish border of the nails,—the symptom which has induced me to narrate the case,—my impression is that it is an illustration of feeble venous circulation.

No. LXXVII.—*Long persisting and recurring Eruptions from the Bites of Insects.*

It is always of much interest to trace the influence of known and simple causes in the production of disease. That the bites of insects assume a *rôle* in reference to certain chronic forms of skin-disease of a far more important character than is usually suspected, is a proposition to which I have very frequently invited attention. Flea bites are a very common cause in children of what is allowed to take rank as prurigo or lichen urticatus. The bites of lice and fleas are, I believe, by far the commonest exciting cause of urticaria pigmentosa; and eruptions on the hands and face, which may assume a chronic or even a relapsing or recurrent type, are often caused, in the first instance, by mosquitoes or gnats. I have had many instructive opportunities for carefully studying the effects of these kinds of irritation in

the persons of intimate friends, whom I have had the opportunity of seeing frequently, and I may claim to speak from exact observation. The fact that papules, which have resulted from poisoned bites or stings, will often disappear for a time and then, after a period of weeks or even months, again become red and irritable, is one which is not so well recognised as it ought to be. I have been tempted to believe that there is a law of periodical recrudescence, which applies to almost all eruptions or isolated papules, which have ever been very irritable. Those who have had the skin made to itch by whatever cause, are often liable for long periods after to recurring attacks of irritability; although there may have been no fresh access of the exciting cause.

I have been induced to make the above remarks on the present occasion, because I have just seen a case which remarkably well exemplifies them.

A very intelligent gentleman came to me this summer with his hands covered with little shotty papules, which were very irritable. They had been troubling him during most of the hot weather of the present summer, and he had also had some on his face. He told me that in the previous autumn his hands and face had been most severely stung by mosquitoes. Intense irritation had been produced, and on his hands little papules, exactly like those which he now had, were developed. During the winter he got quite rid of the irritation, but, when the warm weather came, it relapsed. He assured me that many of the papules which he now showed occupied the exact sites of those which had resulted from mosquito bites nine months ago. Yet during the present summer he had not been bitten, and prior to the attack (which occurred in Venice) he had not considered that his skin was irritable.

No. LXXVIII.—*A Case of Summer Eruption of the Acne Type.*

Miss B—— has been liable to the eruption since the age of 25. She says that she is usually well in the winter; but sometimes suffers from cold winds. She is always worse in

hot weather. Any temporary exposure to sun increases it. As a girl she suffered from chilblains on the feet; but never on the hands, face, or ears. It is believed that she suffered from an eczematous eruption on the head after vaccination. The eruption on the face is very severe, and presents mixed characters of acne and eczema. On the backs of the ears and adjacent parts of cheeks, it appears to have left very superficial scars. The character of the patches is very suggestive of lupus erythematosus of the eczema type. She is clear, however, in her statement that these patches, like the others, disappear in cold weather. On her upper lip and nose the spots are not to be distinguished from those of a lichenoid type of eczema. On the eyes and cheeks, especially near to the ears, they spread into larger patches.

The eruption occurs on the backs of her hands as little isolated red papules, and does not assume the eczematous type. The conditions are exactly like those of Mrs. C——, with the difference that on the face there are patches that are distinctly eczematous. She states that on one occasion, from sitting in the sun on the seashore, the eruption came out very freely on her hands. The eruption does not occur on any other part of the body. She wears a high collar, which protects her neck from exposure.

No. LXXIX.—*A Note on Freckles.*

The liability to the formation of freckles must be taken as a totally different thing from proneness to receive a diffused brown tint of skin from exposure to sun. Those who brown do not blister. As Dr. Bowles has taught us, the pigmentation prevents the injurious influence of the sun's rays. The local pigmentation, which constitutes a freckle, however, and which in some instances leaves an intervening portion of skin pale, has no efficient protective influence. Patients who are much freckled not infrequently suffer from scorching also. The very tendency to freckle possibly proves an abnormal irritability of skin. I have seen this in many instances. The last which has attracted my attention is that of a Captain V——, a gentleman of light hair and blue eyes, who has

travelled much in hot countries. He came to me in August, 1893, after the extremely hot weather which we had then experienced, with both ears swollen and red and covered with little vesications and sores. This was not the thing for which he sought advice, but it attracted my attention. He himself thought nothing of it, saying that he frequently got his ears sore in hot weather. His face was covered with freckles, and on the backs of his hands they were so numerous as to be almost confluent. On his face and hands there were no actual blisters, nothing more than a little roughness of skin in parts.

No. LXXX.—*A Case of Sun Eruption on Face and Hands.*

I have lately seen a very remarkable case, illustrating the influence of exposure to sun in a child. It was indeed almost the counterpart of a case which I published in Archives about a year ago, in which an adult man from South America had become the subject first of freckles, then of vesications and eczematous irritation, and lastly of epithelial cancer, simultaneously on different parts. In the case of the boy, which I am now about to describe, conditions very much like those of rodent ulcer have been developed on the face, and although it cannot be as yet asserted that he is the subject of cancer, he is evidently in great danger of it. This boy is a native of the Cape of Good Hope, and has there been much exposed to the influence of the sun. He is of English parentage, and there is no known family inheritance. He is about nine years of age, and his cheeks and nose are covered with large scars, which have resulted in part from the disease and in part from the treatment which has been adopted. At the edges of some of these scars there are little sinuous, indurated rolls, almost exactly like those which characterise rodent ulcer. On some parts crusts are still present; but there is no tendency either to fungate or to ulcerate deeply. The only other part of the body affected is the backs of the hands, which present a condition of dry exfoliation in patches. This boy has been under much treatment in the colony, having had

the patches scraped and cauterised repeatedly under the diagnosis of lupus. This nominal diagnosis may be admitted to be not without plausibility. The boy has consulted several specialists in London, and at least one has inclined to consider the disease as lupus. Giving, as I am accustomed to do, a very wide meaning to that name, I am not disposed wholly to differ from such a diagnosis. It must be understood, however, that the conditions are essentially very different both from lupus erythematosus and lupus vulgaris, and that their cause has definitely been exposure to the influence of the sun. For those who think that lupus is always consequent on the presence of the tubercle bacillus, this disease is not lupus.

No. LXXXI.—*Hepatic Urticaria.*

Miss P——, a lady of forty, sent to me by Dr. Gardner, of Shrewsbury, afforded an example of what we may call hepatic urticaria. Twelve years ago, in connection with a fire, she had been much frightened, and was afterwards laid up for three months with congestion of the liver. During this attack she was yellow, but, as she believed, never deeply jaundiced. Ever since she had been liable to sudden attacks in which her skin and eyes would become yellow, with much depression of spirits and discomfort about the region of the liver. For three years she had been liable to extreme irritability of the skin, accompanied by an eruption of small red papules. Her skin was usually very dry and would bruise very easily. The eruption had usually been worst in spring and autumn. It wandered a good deal from one place to another, usually affecting the limbs, and had never been absent from the axillæ. It was worse in cold weather.

Miss P—— was of pale complexion and slightly yellow. She was easily made breathless, and complained much of lassitude. The irritation she said was intolerable, and averred that unless cured she could not support life. She had found out that fish (cod and mackerel), were poisonous to her, and that quinine and coffee disagreed. She was always worst in cold weather.

PLATE CXI.

RODENT CANCER IN A YOUNG MAN.

This portrait belongs to the case reported at page 44 of the last number of 'Archives.' It exhibits a well characterised rodent ulcer with a hard, rolled, sinuous border, which had been spreading for nearly ten years in a man, who, at the time the portrait was taken, was only twenty-five. It had been twice excised, and had twice recurred. A most interesting point in the history of the case is that the young man's father had been the subject of rodent cancer for many years before his son's birth. He (the father) died of the disease thirty years after its commencement, with the greater part of his face eaten away.

In the present case my son performed a third operation, freely excising the growth, and transplanting on to the wound a large flap of skin from the forehead. The result appeared to be very satisfactory when the patient was last seen, but it is much to be feared that the disease will sooner or later return.

West, Newman chro

SYPHILIS.

No. LXIV.—*Phagedænic Ulceration of the Face in connection with Inherited Syphilis.*

One of the most deplorable cases that I have ever seen of this nature occurred in the case of a young man named H——, who was brought to me by Dr. Thorne. I was informed that the family history was complete; Dr. Thorne having known the parents and the patient from his infancy. There was, however, no need for any history, for the poor lad was absolutely deaf and had typically notched teeth. The principal feature of interest was the existence of very extensive phagedænic ulceration, involving the parts around the right orbit. The eye itself had been removed about eighteen months before I saw him, and so far as I could get at the facts, it appeared that the wound had been attacked by a sort of chronic phagedæna, which had existed to the present time. It had, however, been much aggravated of late. At the time of his visit to me, the ulcer included the entire orbit and the greater part of the cheek and forehead. It was almost exactly round and presented everywhere an abrupt elevated edge, not much unlike that of a rodent ulcer. There was, however, more of inflammation and of unhealthy secretion about it than is seen in the latter malady. The phagedænic action, however, was chronic rather than acute. The whole of the parts involved in the ulceration were considerably swollen. There was a large ulcer of a similar character, though much less severe in type, under his right ear.

There were some other facts of interest about this case apart from the chronic phagedæna which I have described. The youth was evidently the subject of a general arrest of

development, and although eighteen, he did not look more than twelve. His deafness was absolute. There was a history that he had formerly suffered from paraplegia, but of that he had wholly recovered. He had been treated by the late Mr. George Critchett during his attack of keratitis eight or ten years ago, and had subsequently been under the care of Mr. Field for his deafness.

The results of treatment in this case were most satisfactory. The enormous size of the ulcer made me reluctant to use the caustic acid nitrate (according to custom), and I contented myself by prescribing the three iodides and an iodoform ointment. Under these in about two months the ulcers had healed.

No. LXV.—*Syphilitic Stricture of the Œsophagus.*

It is an interesting question whether there be such a thing as syphilitic stricture of the œsophagus. I allude, of course, to the lower parts of the tube, for we undoubtedly encounter very troublesome contractions, after ulceration, in the upper part. Dr. Beaumont, of Gipsy Hill, has just informed me of the sequel of a case of considerable interest with reference to this point. He tells me that a gentleman whom he brought to me two years ago, and in whom malignant stricture was suspected, has entirely recovered, and is now in good health and able to swallow easily. On referring to my notes of the case, I find that with considerable difficulty, under an anæsthetic, I got a bougie through a contraction in the lower part of the tube; as the patient had suffered from syphilis, and on account of the absence of some of the symptoms of cancer, we decided to use bougies as a measure of treatment, and to give iodide of potassium.

It was under these measures that the recovery took place, and for a year past no bougie had been employed.

No. LXVI.—*Difficult Diagnosis between Pityriasis Rosea and a Syphilitic Eruption.*

One of the most puzzling eruptions which I have recently seen occurred in the person of a young officer named D——.

He was only twenty-two years of age, and had, so far as he knew, never before had syphilis. Eighteen months before he came to me, he had what were diagnosed as "soft sores" just within the meatus. They lasted two weeks or so, and were not followed by any constitutional symptoms, but during the next few months they recurred several times. Three weeks before his coming to me he had a sore on the skin of the prepuce, and almost simultaneously with it he developed a copious eruption. As he had been frequently exposed to risk of contagion, no doubt was entertained that the sore and the eruption were both of them syphilitic, and mercury in fair doses was at once commenced. He had taken it for three weeks, when he was sent to me because the eruption did not fade. I found, on examination of his penis, some little indefinite spots on the skin of its under surface. They were not indurated in the slightest degree. His eruption consisted of erythematous desquamating patches, which were scattered over his whole trunk and upper limbs. Most of them were rather abruptly defined, and it was remarkably uniform in all parts. It was much more plentiful on the trunk than on the limbs, and was very abundant on the back of the neck. There were a few very slightly marked patches on his face. I could not distinguish the eruption from a severe example of pityriasis rosea, and although there were some suspicious appearances on one tonsil, I ventured to tell him that I did not feel certain that he had syphilis, and advised him to discontinue the mercury. At his next visit, a week later, the eruption was fading everywhere, and there was nothing more characteristic in his throat. There were some little sores in one cheek that looked liked herpes. A week later still the eruption had almost wholly disappeared, nothing but a slight diffuse scaliness remaining. The little sores on the skin of his penis and in the meatus had also quite disappeared.

The treatment which I had adopted was the use of sulphur baths every other day.

MISCELLANEOUS.

No. CXXXIII.—*Syphilitic simulations of Bazin's Malady.*

It may seem strange, after having asserted that one of the most important facts in reference to Bazin's malady is that it very closely simulates syphilis, that it should be thought worth while to ask attention to the converse fact, and to say that syphilis very frequently simulates it. Yet the latter proposition is probably the more accurate way of stating the facts. Bazin's malady is the type and, when it occurs in connection with syphilis, we ought probably to regard it rather as a specific modification than as a wholly distinct disease. In asserting that there are syphilitic simulations of it, I do not refer to ordinary forms of syphilitic ulcerations on the legs. Many of these occur in connection with syphilitic ulcerations on other parts, and many others are definitely of a lupoid type, *i.e.*, spreading serpiginously and to an indefinite extent. The ulcers of Bazin's malady are not at all like those of lupus. When in a case of syphilis, a patient has the legs covered with ulcers, which begin in the subcutaneous tissue and not on the surface, and which are confined to the legs, we have presented a resemblance to Bazin's malady, which certainly ought not to escape notice. The cases differ only from the scrofulous form of Bazin's disease in that they are easily and definitely cured by specific treatment. Well-marked examples of this are by no means common, and when cases do occur, they are probably due to a partnership causation, differing only from that of the other form in that syphilis comes in as an additional partner. I admit that the difference is a very great one; but we should do wrong to exaggerate it. The partnership in the non-

PLATE CIX.

BAZIN'S MALADY.—MULTIPLE ULCERS ON THE LEGS.

This portrait represents the condition of things in Case 1, published in the 'Archives,' vol. v., page 35. The patient was a girl of thirteen, under the care of Dr. Colcott Fox, by whom another portrait, taken independently, was preserved. The girl had suffered from the ulcers of the legs for about four months. There was much dusky erythema, and the edges of the ulcers were considerably undermined. There was no reason to suspect syphilis; but there was a definite history of scrofula, both in the patient herself and her family.

[Dr. Fox has already published his portrait in the 'Dermatological Journal' for August last, and I must apologise to him for publishing another. Mine had been executed before I knew of his intention, and it seemed a pity to waste the impressions. The reader may compare them with advantage, and also read Dr. Fox's excellent paper.]

West, Newman chromo.

specific forms of Bazin's disease is probably (α) a scrofulous tendency, (β) the peculiarities of the part as regards circulation, (γ) slight injuries, pricks, stings, bruises, &c., to which the legs are especially exposed. All these influences are probably present also in the cases in which close simulations are produced during the course of syphilis. We have precisely the same problem before us as in the case of syphilitic lupus.

A very definite simulation of Bazin's malady occurred in the case of a young officer from India. His legs from the knee downward were, when I saw him, covered with sound scars. Excepting that they were more deeply pigmented at their edges, they were exactly like those of Master R—— (see plate given in last number). He had had no ulcers on other parts of his body, the disease having been wholly restricted to his legs. Some of the ulcers had, however, occurred lower down, on the ankles, than is usual in the scrofulous cases. He attributed the ulcers on his legs to local irritation, pricks, stings, &c., whilst shooting in the jungle ; but they occurred at a time when he was suffering from secondary syphilis, and they were cured by specific treatment. It is, perhaps, worthy of note in this case that the patient had had, during his secondary stage, an attack of jaundice, which had cleared off well (functional jaundice). He had also become very deaf in his left ear.

No. CXXXIV.—*Alternation between Catarrhal Susceptibility and Melancholia.*

Mrs. R——, a lady of 55, usually enjoying fair health and good spirits, but liable to states bordering on melancholia, made the following interesting statements. "When I am depressed I never catch colds, and my nose is usually quite dry; I seldom need a handkerchief. But when I am well I am constantly taking cold, and frequently have attacks of sneezing and nose-running which compel me to use many handkerchiefs in a morning. The first sign of my depression state passing away is usually taking a cold." Mrs. R——'s periods

of depression had occurred four or five times when I saw her, and had more than once lasted for six or nine months continuously. She assured me repeatedly that during them she might be exposed to cold or draughts or damp to any extent, and nothing of the nature of catarrhal symptoms ever followed.

No. CXXXV.—*Epithelial cancer in the mouth in a father and son at the same age.*

Lieutenant C——s came under my observation with epithelial cancer of the hard palate. He was forty-one years of age. His father had died at exactly the same age with cancer of the tongue and secondary implication of glands. He had been seen by Sir James Paget, but too late for operation.

No. CXXXVI.—*Bold Surgery in bygone Times.*

The German Emperor Frederic III: submitted to amputation for an ulcerated leg at the age of seventy-nine. He sank after the operation (1493).

No. CXXXVII.—*Lucretius on Monsters.*

The following extract from Lucretius displays an extensive knowledge of the various forms of congenital defects in development:—

"Some that to neither sex their title proved,
And yet from neither sex were far removed:
Some, short of feet, some, wanting hands, arise,
Some without mouths, and some devoid of eyes.
Here to lax limbs distorted limbs adhered,
There, disproportioned all the frame appeared;
Cramped was each member, part with part at strife,
And each refused the offices of life:
To walk, to act, their nerveless powers deny."

"*The Nature of Things*," Book v.

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CATALOGUS LIBRORUM

RICHARDI MEAD, M.D.

QUI

Prostabunt Venales sub Hasta,

Apud SAMUELEM BAKER,

In Vico dicto *York Street*, *Covent Garden*, *Londini*,

Die Lunæ, 18^vo. *Novembris*, M.DCC.LIV.

ITERUMQUE

Die Lunæ, 7^mo. *Aprilis*, M.DCC.LV.

Γεῦμα τὴν ὠνὴν καλεῖ. EURIPID.

CATALOGI venundantur apud plurimos Londini Bibliopolas, et in omnibus Urbibus Europæ celebrioribus, unius Solidi Pretio.

CATALOGUE OF MEAD'S LIBRARY AND MUSEUM.

I HAVE had given me, by a medical friend who takes a laudable interest in the history of medicine, a Catalogue of the Library of Dr. Richard Mead, as arranged for sale by auction. Mead died in 1754, and the sale was in November of the fifty-fourth and April of the fifty-fifth years of the eighteenth century. The auctions of that day must have been exceedingly tedious, for the books were sold in separate lots, and no fewer than fifty-two days were taken up. The whole of the Catalogue, with its short prefaces, is in Latin. In stating the conditions of sale, however, and also in explaining some errata which had crept into the descriptions, the auctioneer has thought it best to resort to the vernacular tongue. My copy has the prices of every lot written in.

Mead had collected books of all classes, more especially in the classics and theology. The best prices obtained were for Bibles. As a rule the prices did not run high. Thus we may note that Baker's "Microscope Made Easy," 1745, sold for four-and-sixpence; Newton's "Arithmetica Universalis," Cantab., 1707, for eighteenpence; Needham's "Microscopical Discoveries," 1745, for three-and-sixpence, and a translation of the same into French for three shillings.

I believe that Messrs. Christie and Manson possess a priced catalogue of John Hunter's books, pictures, &c., which were sold by auction in their rooms. Probably other copies exist in private hands, but I never saw one. Sir James Paget in his "Hunterian Oration" quoted from the one referred to. Hunter's sale was nearly forty years later than that of Mead. It may be of interest to note that, whilst Hunter looked on the microscope almost with contempt, and ridiculed the supposed discovery of the Itch insect, Mead possessed four

microscopes designed for different purposes. The following is the auctioneer's description of them :—

Microscopium parvum, duplicis reflexionis, a *Campani* Romæ, 1696, constructum.

Alterum majori forma, cum omni ejus apparatu, elegantis opificii. *A Joanne Cuff.*

Aliud cum apparatu rarii generis, nimirum camera obscura, speculo concavo vitreo, et argenteis speculis ad objecta opaca melius perlustranda. *Ab eodem artifice.*

Aliud ad polypos, aliaque objecta aquatica contemplanda præcipue accommodatum. *Ab eodem.*

It will be seen that one of these instruments was already fifty years old, and of Italian manufacture.

The following items are of interest, as indicating the knowledge of the day and the objects which had been collected :—

Under VEGETABILIA we have—

Fvngus marinus cerebriformis.

Campylium ramosum reticulare ; Anglicè, Sea-fan.

Under ANIMALIA cum partibus eorum—

Tænia sive lumbricus latus.

Lapis singularis in vesica equi repertus : pond. = 11 unc : 10 den.

Hirvndo piscis, pinnas duas habens a branchiis usque ad caudam extendentes, quarum ope aqua exiliens in aere paulisper se suspendere potest.